



**CERTIFICATION APPLICATION
QUALIFIED HEALTH PLAN
INDIVIDUAL MARKETPLACE
PLAN YEAR 2028
DRAFT – CLEAN
09.14.2026**

Certification Application Qualified Health Plan Individual Market Plan Year 2028 **DRAFT - CLEAN**

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1 Application Overview

1.1 Purpose

The California Health Benefit Exchange (Covered California) is accepting applications from eligible Health Insurance Issuers (Applicants or Health Issuer) to submit proposals to offer, market, and sell Qualified Health Plans (QHPs) through Covered California, beginning in 2027 for coverage effective January 1, 2028. All Health Insurance Issuers currently licensed at the time of application response submission are eligible to apply for certification of proposed Qualified Health Plans (QHPs) for Plan Year 2028. Covered California will exercise its statutory authority to selectively contract for health care coverage offered through Covered California for Plan Year 2028. Covered California reserves the right to select or reject any Applicant or to cancel this Application at any time.

1.2 Background

Soon after the passage of national health care reform through the Patient Protection and Affordable Care Act of 2010 (ACA), California enacted legislation to establish a qualified health benefit exchange (California Government Code § 100500 et seq.) The California state law is referred to as the California Patient Protection and Affordable Care Act (CA-ACA).

Covered California offers a statewide health insurance exchange to make it easier for individuals to compare plans and buy health insurance in the private market. Although the focus of Covered California is on individuals who qualify for tax credits and subsidies under the ACA, Covered California's goal is to make insurance available to all qualified individuals. The vision of Covered California is to improve the health of all Californians by assuring their access to affordable, high quality care coverage. The mission of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Covered California is guided by the following values:

Consumer-Focused: At the center of Covered California's efforts are the people it serves. Covered California will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those it serves.

Affordability: Covered California will provide affordable health insurance while assuring quality and access.

Catalyst: Covered California will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

Integrity: Covered California will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.

Transparency: Covered California will be fully transparent in its efforts and will make opportunities available to work with consumers, providers, health plans, employers, purchasers, government partners, and other stakeholders to solicit and incorporate feedback into decisions regarding product portfolio and contract requirements.

Commitment: Covered California values partners who demonstrate sustained commitment to California consumers and to the strength and stability of the marketplace.

Results: The impact of Covered California will be measured by its contributions to decrease the number of uninsured, have meaningful plan and product choice in all regions for consumers, improve access to quality healthcare, promote better health and health equity, and achieve stability in healthcare premiums for all Californians.

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In addition to being guided by its mission and values, Covered California's policies are derived from the federal ACA which calls upon Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. Covered California seeks to improve the quality of care while moderating cost not only for the individuals enrolled in its plans, but also by being a catalyst for delivery system reform in partnership with plans, providers, and consumers. With the Affordable Care Act and the range of insurance market reforms that are in the process of being implemented, the health insurance marketplace is transforming from one that has prioritized profitability through a focus on risk selection, to one that rewards better care, affordability, and prevention.

Covered California needs to address these issues for the millions of Californians who enroll through Covered California to get coverage, but it is also part of broader efforts to improve care, improve health, and stabilize rising health care costs throughout the state.

Covered California must operate within the federal standards in law and regulation. Beyond what is framed by the federal standards, California's legislature shapes the standards and defines how the new marketplace for individual and small group health insurance operates in ways specific to their context. Within the requirements of the minimum Federal criteria and standards, Covered California has the responsibility to "certify" the Qualified Health Plans that will be offered in Covered California.

The state legislation to establish Covered California gave authority to Covered California to selectively contract with Issuers to provide health care coverage options that offer the optimal combination of choice, value, quality, and service, and to establish and use a competitive process to select the participating health Issuers. To this end, Covered California only certifies those Applicants who demonstrate a clear value proposition to its consumers, both in terms of quality and price; in addition, QHPs already operating on the Exchange must maintain quality scores that meet or exceed established benchmarks and reduce health disparities, or risk being removed from the Exchange.

These concepts, and the inherent trade-offs among Covered California values, must be balanced in the evaluation and selection of the Qualified Health Plans (QHPs) that will be offered on the Individual Exchange.

This application has been designed consistent with the policies and strategies of the California Health Benefit Exchange Board which calls for the QHP selection to influence the competitiveness of the market, the cost of coverage, and how value is added through health care delivery system improvement.

1.3 Application Evaluation and Selection

The evaluation of QHP Certification Applications will not be based on a single, strict formula; instead, the evaluation will consider the mix of health plans for each region of California that best meets the needs of consumers in that region and Covered California's goals. Covered California wants to provide an appropriate range of high-quality health plans to participants at the best available price that is balanced with the need for consumer stability and long-term affordability. In consideration of the mission and values of Covered California, the Board of Covered California articulated guidelines for the selection and oversight of Qualified Health Plans which are used when reviewing the Applications. These guidelines are:

Promote Affordability and Value for the Consumer- Both in Premiums and at Point of Care

While premiums will be a key consideration, contracts will be awarded based on the determination of "best value" to Covered California and its participants. Covered California seeks to offer health plans, plan designs and provider networks that are as affordable as possible to consumers, both in premiums and cost sharing, while fostering competition and

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stable premiums. Covered California will seek to offer health plans, products, and provider networks that will attract maximum enrollment as part of its effort to lower costs by spreading risk as broadly as possible.

Encourage Competition Based upon Quality

The evaluation of Applicant QHP proposals will focus on quality and service components, including history of performance, administrative capacity, reported quality and satisfaction metrics, quality improvement plans, and commitment to serve Covered California's population. The application responses, in conjunction with the approved filings, will be evaluated by Covered California and used as part of the selection criteria to offer Applicant's products on Covered California for the certification year. In addition, supplemental contracted provider network data will be used to predict the likely quality of new entrant QHPs to ensure that new entrants are held to the same quality standards as existing QHPs. Proposed provider networks will be evaluated using provider-organization quality data, hospital quality data, and health plan quality results. These would include National Committee for Quality Assurance (NCQA) commercial and Medicaid Healthcare Effectiveness Data and Information Set (HEDIS) measure results, and Quality Rating System (QRS) Marketplace measure results from other states.

Encourage Competition Based upon the Populations Served

Performing effective outreach, enrollment and retention of the low-income population that will be eligible for premium tax credits and cost sharing subsidies through Covered California is central to Covered California's mission. Responses that demonstrate an ongoing commitment to the low-income population or demonstrate a capacity to serve the cultural, linguistic and health care needs of the low-income and uninsured populations beyond the minimum requirements adopted by Covered California will receive additional consideration. Examples of demonstrated commitment include having a higher proportion of essential community providers to meet the criteria of sufficient geographic distribution; having contracts with Federally Qualified Health Centers; and supporting or investing in providers and networks that have historically served these populations to improve service delivery and integration. This commitment to serve Covered California's population is evidenced through general cooperation with Covered California's operations and contractual requirements which include provider network adequacy, quality improvement, cultural and linguistic competency, programs addressing health equity and disparities in care, innovations in delivery system improvements, and payment reform.

Encourage Competition Based upon Meaningful QHP Choice and Product Differentiation: Patient-Centered Benefit Plan Designs¹

Covered California is committed to fostering competition by offering QHPs with features that present clear choice, product, and provider network differentiation. QHP Applicants are required to adhere to Covered California's standard benefit plan designs in each region for which they submit a proposal. In addition, QHP Applicants may offer Covered California's standard Health Savings Account-eligible (HSA) High-Deductible Health Plan (HDHP) designs. Applicants may choose to offer either or both Gold and Platinum standard benefit plan designs if there is differentiation between two (2) plans in the same metal tier that is related to either product, network, or both, or an additional benefit explained. Covered California is interested in having Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), Preferred

¹ The certification year Patient-Centered Benefit Plan Designs will be finalized when the certification year federal actuarial calculator is finalized.

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Provider Organization (PPO), and other products offered statewide. Within a given product design, Covered California will look for differences in network providers and the use of innovative delivery models. Under such criteria, Covered California may choose not to contract with two (2) plans which have broad overlapping networks within a rating region - unless they offer different innovative delivery system or payment reform features.

Encourage Competition throughout the State

Applicants must submit QHP proposals in all geographic service areas in which they are licensed and have an adequate network. Preference will be given to Applicants that develop QHP proposals that meet quality and service criteria while offering coverage options that provide reasonable access to the geographically underserved areas of the state.

Encourage Delivery System Improvement, Effective Prevention Programs and Payment Reform

One of the values of Covered California is to serve as a catalyst for the improvement of care, prevention, and wellness, in order to reduce costs. Covered California encourages QHP offerings that incorporate innovations in delivery system improvement, prevention, and wellness and/or payment reform that will help foster these broad goals. This will include models of patient-centered medical homes, targeted quality improvement efforts, participation in community-wide prevention, or efforts to increase reporting transparency to provide relevant health care comparisons and to increase member engagement in decisions about their course of care.

Demonstrate Administrative Capability and Financial Solvency

Covered California will review and consider Applicant's degree of financial risk to avoid potential threats of failure which would have negative implications for continuity of patient care and for the healthcare system. Applicant's technology capability is a critical component for success for Covered California, so Applicant's technology and associated resources are heavily scrutinized as this relates to long-term sustainability for consumers. Application responses that demonstrate commitment to the long-term success of Covered California's mission are strongly encouraged.

Encourage Robust Customer Service

Covered California is committed to ensuring a positive consumer experience, which requires Applicants to maintain adequate resources to meet consumers' needs. To successfully serve Covered California consumers, Applicants must invest in and sustain adequate staffing, including hiring of bilingual and bicultural staff as appropriate and maintaining internal training as needed. Applicants demonstrating a commitment to dedicated administrative resources for Covered California consumers will receive additional consideration.

Ensure QHPs Offer Stable Products and Provider Networks that Support Consumer Confidence and Peace of Mind

Covered California is committed to offering QHPs that provide consumers with reliable, predictable coverage and continuity of care over time. Covered California will review and consider an Applicant's demonstrated commitment to the market and history of stability across pricing, geographic footprint, product offerings, and provider networks; approach to minimizing disruption resulting from provider, service-area, or product changes; strategies to support

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continuity of care; and ability to ensure adequate access. Applicants should demonstrate the administrative, operational, and financial capacity to sustain a long-term market presence, deliver consistent service, and fulfill contractual obligations. Together, these commitments strengthen consumer confidence and provide individuals and families with peace of mind when selecting and using their QHP.

1.4 Availability

Applicant must be available immediately upon contingent certification of their plans as QHPs to start working with Covered California to establish all operational procedures necessary to integrate and interface with Covered California information systems and to provide additional information necessary for Covered California to market, enroll members, and provide health plan services effective January 1, 2028. Successful Applicants will also be required to adhere to certain provisions through their contracts with Covered California, including meeting data interface requirements with the California Healthcare, Eligibility, Enrollment, and Retention System (CalHEERS). Successful Applicants must execute the QHP Issuer Contract before public announcement of contingent certification. Failure to execute the QHP Issuer Contract may preclude Applicant from offering QHPs through Covered California. The successful Applicants must be ready and able to accept enrollment as of October 1, 2027.

1.5 Application Process

The application process shall consist of the following steps:

- Completion of Letter of Intent to Apply
- Release of the Final Application
- Submission of Applicant responses
- Evaluation of Applicant responses
- Discussion and negotiation of final contract terms, conditions, and premium rates
- Execution of contracts with the selected QHP Issuers

1.6 Intention to Submit a Response

Applicants interested in responding to this application must submit a non-binding Letter of Intent to Apply, identifying their proposed products and service areas. Only those Applicants who submit the Letter of Intent will receive application-related correspondence throughout the application process. Eligible Applicants who have responded to the Letter of Intent will be issued a login and instructions for online access to the final Application.

Applicant's Letter of Intent must identify the contact person for the application process, including their email address and telephone number. On receipt of the Letter of Intent, Covered California will issue instructions to gain access to the online Application. A Letter of Intent will be considered confidential and not available to the public. However, Covered California reserves the right to release aggregate information about all Applicants' responses. Final Applicant information is not expected to be released until the selected Issuers and QHPs are announced. Applicant information will not be released to the public but may be shared with appropriate regulators as part of the cooperative arrangement between Covered California and the regulators.

Covered California will correspond with only one (1) contact person per Application. It is Applicant's responsibility to immediately notify the Application Contact identified in this section, in writing, regarding any revision to the contact information. Covered California is not responsible for application correspondence not received by Applicant if Applicant fails to notify Covered California, in writing, of any changes pertaining to the designated contact person.

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Application Contact: Libby Bennett
QHPCertification@covered.ca.gov
(916) 954-3138

1.7 Key Action Dates

Action	Date/Time
Draft Application Released for Public Comment	September 14 - 30, 2026
Letter of Intent to Apply due to Covered California	February 12, 2027
Application Opens	March 1, 2027
Completed Applications Due (include the certification year proposed Rates and Networks)	April 29, 2027, at noon (12:00 pm PT)
Negotiations between Applicants and Covered California	June 2027
Final QHP Contingent Certification Decisions	July 2027
QHP Contract Execution	September 2027
Final QHP Certification	October 2027

1.8 Preparation of Application Response

Application responses are completed in an electronic proposal software program. Applicants will have access to a Question-and-Answer function within the portal and must submit questions related to the Application through this mechanism.

Applicants must respond to each Application question as directed by the response type. Responses should be succinct and address all components of the question. Applicants may not submit documents in place of responding to individual questions in the space provided.

2 Administration and Attestation

Questions 2.1 – 2.3 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

2.1 Applicant must complete the following:

	Response
Issuer Legal Name	10 words.
Entity name used in consumer-facing materials or communications	10 words.
NAIC Company Code	10 words.
NAIC Group Code	10 words.
California State Regulator(s)	10 words.
Federal Employer ID	10 words.
HIOS/Issuer ID	10 words.
Applicant tax status	Single, Pull-down list. 1: Not-for-profit 2: For-profit

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Year Applicant was founded	10 words.
Number of Years Applicant has been a California licensed Health Issuer	10 words.
Applicant's Covered California Individual Operation Status	<i>Single, Pull-down list.</i> 1: Currently operating in Covered California 2: Not currently operating in Covered California
Corporate Office Address	10 words.
City	10 words.
State	10 words.
Zip Code	10 words.
Primary Contact Name	10 words.
Contact Title	10 words.
Contact Phone Number	10 words.
Contact Email	10 words.
On behalf of Applicant stated above, I hereby attest that I meet the requirements in this Application and certify that the information provided on this Application and in any attachments hereto are true, complete, and accurate. I understand that Covered California may review the validity of my attestations, and the information provided in response to this application, and that if an Applicant is selected to offer Qualified Health Plans, may decertify those Qualified Health Plans should any material information provided be found to be inaccurate. I confirm that I have the capacity to bind the issuer stated above to the terms of this Application.	
Date	To the day.
Signature	10 words.
Printed Name	10 words.
Title	10 words.
Email Address	10 words.
Phone Number	10 words.

2.2 Applicant must complete the following table for individuals in Applicant's organization that hold these job titles or are responsible for equivalent job duties.

Key Individual	Name	Email Address	Phone Number
Chief Executive Officer	10 words.	10 words.	10 words.
Chief Finance Officer	10 words.	10 words.	10 words.
Chief Operations Officer	10 words.	10 words.	10 words.
Chief Medical Officer	10 words.	10 words.	10 words.
Dedicated Covered California Liaison	10 words.	10 words.	10 words.

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2.3 Does Applicant anticipate making material changes in corporate structure in the next 24 months, including but not limited to the following. If Applicant anticipates material changes, Applicant must provide a brief description of those changes.

	<i>Response</i>	<i>Description</i>
Mergers	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i>
Acquisitions	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i>
New venture capital	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i>
Management team	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i>
Location of corporate headquarters or tax domicile	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i>
Stock issue	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i>
Other	<i>Single, Pull-down list.</i> 1: Yes, 2: No	<i>200 words.</i>

2.4 Applicant must complete the following table of current Certificates of Insurances specified below.

Coverage	Amount	Applicant must confirm if the coverage amount meets requirement.	Does the current policy expire before the end of the current Plan Year? If yes, Applicant must indicate the date when the new policy starts.
Commercial General Liability	<i>For comparison.</i> Limit of not less than \$1,000,000 per occurrence/ \$2,000,000 general aggregate.	<i>Compound, Pull-down list.</i> 1: Confirmed 2: Not confirmed describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words] 2: No
Cyber Liability	<i>For comparison.</i> At such levels consistent with industry standards and reasonably determined by Contractor to cover network security, unauthorized access, unauthorized use, receipt or transmission of a malicious	<i>Compound, Pull-down list.</i> 1: Confirmed 2: Not confirmed describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words] 2: No

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	code, denial of service attack, unauthorized disclosure or misappropriation of private information and privacy liability Protected Health Information and Personally-Identifiable Information		
Employers Liability Insurance	<i>For comparison.</i> Limits of not less than \$1,000,000 per accident for bodily injury by accident, and \$1,000,000 per employee for bodily injury by disease, and \$1,000,000 disease policy limit.	<i>Compound, Pull-down list.</i> 1: Confirmed 2: Not confirmed describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words] 2: No
Umbrella Policy	<i>For comparison.</i> An amount not less than \$10,000,000 per occurrence and in the aggregate.	<i>Compound, Pull-down list.</i> 1: Confirmed 2: Not confirmed describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words] 2: No
Statutory CA's Workers' Compensation Coverage	<i>For comparison.</i> Provide Proof of Coverage in full compliance with State law.	<i>Compound, Pull-down list.</i> 1: Confirmed 2: Not confirmed describe: [50 words]	<i>Compound, Pull-down list.</i> 1: Yes, [50 words] 2: No

2.5 Applicant must attach a combined copy of current Certificates of Insurance to verify that it maintains the insurance specified in table 2.4. If all applicable Certificates of Insurance are not attached, Applicant must explain why.

Single, Radio group.

1: Attached, if not all certificates are attached explain why: [200 words] ,

2: Not attached, explain: [200 words]

2.6 Applicant must indicate if it has any experience participating in exchanges or marketplace environments.

State-based Marketplace(s), specify state(s) and years of participation	100 words.
Federally Facilitated Marketplace, specify state(s) and years of participation	100 words.
Private exchange(s), specify exchange(s) and years of participation	100 words.

3 Licensed and Good Standing

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level.

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3.1 Applicants are required to retain proper licensure by the applicable regulator to be certified and operate as an Issuer on Covered California. Applicant must indicate license status below.

Single, Radio group.

- 1: Applicant currently holds all of the proper and required licenses from the California Department of Managed Health Care to operate as a Health Issuer as defined herein in the commercial individual market,
- 2: Applicant currently holds all of the proper and required licenses from the California Department of Insurance to operate as a Health Issuer as defined herein in the commercial individual market,
- 3: Applicant is currently applying for licensure from the California Department of Managed Health Care to operate as a Health Issuer as defined herein in the commercial individual market. Applicant must provide the date the licensing application was filed and provide the current filing status for licensure at the time the Covered California Application is due: [50 words] ,
- 4: Applicant is currently applying for licensure from the California Department of Insurance to operate as a Health Issuer as defined herein in the commercial individual market. Applicant must provide the date the licensing application was filed and provide the current filing status for licensure at the time the Covered California Application is due: [50 words] ,
- 5: Applicant is not currently licensed in the commercial individual market to operate as a health issuer as defined herein by the California Department of Managed Health Care or the California Department of Insurance, and has not applied for licensure to operate as a health issuer in the commercial individual market with either of these entities.

3.2 Applicant must confirm that it will adhere to requirements, including filing due dates and timely responses to correspondence, set forth by the California Department of Managed Health Care or California Department of Insurance, applicable to its licensure and to its QHP proposals. If Applicant cannot adhere to the requirements, Applicant must explain why.

Single, Pull-down list.

- 1: Confirmed, Applicant will adhere to requirements, filing due dates, and provide timely responses to the applicable regulator
- 2: Not Confirmed, Applicant will not adhere to requirements, filing due dates, and provide timely responses to the applicable regulator, explain [200 words]

3.3 In addition to holding or pursuing all the proper and required licenses to operate as an Issuer on Covered California, Applicant must confirm that it has had no material fines, no material penalties levied or material ongoing disputes, for any licensed entity (health or dental) with applicable licensing authorities in the last two (2) calendar years (See Section 21 Glossary - Definition of Good Standing). If Applicant has any material disputes, any enforcement actions resulting in monetary penalties equal to or exceeding \$100,000, identified by State and Federal Regulators, with the applicable insurance regulator in the last two (2) calendar years, Applicant must provide notification of disputes as an attachment in a combined PDF document. Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for determining Good Standing.

Single, Radio group.

- 1: Confirmed, no material disputes in the last two (2) years
- 2: Not confirmed, notification of material disputes attached: [200 words]

4 Financial Requirements

Questions 4.4 – 4.6 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

4.1 Applicant must describe the systems used to invoice members and record the collection of payments. Description of system must include:

- System Name
- Length of time current system has been in place

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- Review process for system accuracy
- System reporting ability and timeliness
- Record retention schedule.

If not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to invoicing, if applicable, and an implementation work plan, including a timeframe.

200 words.

4.2 Applicant must confirm which systems it has in place to accept payment from members, effective no later than the beginning of October prior to the coverage year for the following premium payment types (electronic payments, debit, and credit cards for binder payments are required.):

Multi, Checkboxes.

- 1: Paper checks
- 2: Cashier's checks
- 3: Money orders
- 4: Electronic Funds Transfer (EFT)
- 5: Credit cards
- 6: Debit cards
- 7: Web-based payment, which may include accepting online credit card payments, and all general purpose pre-paid debit cards and credit card payment
- 8: Cash
- 9: Other, list additional forms of payment accepted not listed above: [100 words]

4.3 Applicant must be able to accept premium payment from members no later than October 1st prior to the coverage year. If systems to accept payment are not currently in place, describe plans to implement such systems, including the use of vendors for any functions related to premium payment, if applicable, and an implementation work plan.

Note: QHP Issuer must accept electronic payments, such as debit and credit cards for binder payments. Electronic payment is encouraged, but not required, for payment of ongoing invoices.

200 words.

4.4 Applicant must confirm it will comply with federal requirement 45 CFR 156.1240(a)(2) to serve the unbanked, specifying the forms of payment available for this population for both binder and ongoing payments, and for both on-Exchange and off-Exchange lines of business. Applicant must describe how it will work through (both operationally and systematically) any differences between payment process for the unbanked and usual payment processing procedures and must describe in detail how these types of payments are handled both in and out of their system of record.

Single, Radio group.

- 1: Confirmed, [500 words]
- 2: Not confirmed

4.5 Applicant must confirm no fees, no charges, and no administrative fees will be imposed on any member who requests paper premium invoices for any individual products or services sold by Applicant in California or on any member requesting termination of coverage.

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

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4.6 Applicant must confirm that it accepts premium payments made by or on behalf of an enrollee in connection with health reimbursement arrangements, in compliance with 45 C.F.R. § 156.1240.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

5 Operational Capacity

5.1 Issuer Operations and Account Management Support

Questions 5.1.1 and 5.1.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

5.1.1 Applicant must complete Attachment A1 A2_QHP-IND-CCSB_Current and Projected Enrollment for California On-and Off-Exchange. Applicant must complete all data points for their lines of business (including Employer-Based coverage, Individual Market, and Government Payers) to provide current enrollment and enrollment projections. Failure to complete Attachment A1 A2_QHP-IND-CCSB_Current and Projected Enrollment will require a resubmission of the templates.

Single, Pull-down list.

1: Attached

2: Not attached

5.1.2 Applicant must provide a brief description and timeline (over the next 24 months) of any initiatives which may impact the delivery of services to Covered California Enrollees.

	Response	Description and timeline (over the next 24 months)
System changes or migrations	<i>Single, Pull-down list.</i> 1: Yes 2: No 3: Not Applicable	200 words.
Call center opening	<i>Single, Pull-down list.</i> 1: Yes 2: No 3: Not Applicable	200 words.
Call center closings	<i>Single, Pull-down list.</i> 1: Yes 2: No 3: Not Applicable	200 words.
Call center relocations	<i>Single, Pull-down list.</i> 1: Yes 2: No 3: Not Applicable	200 words.
Network re-contracting	<i>Single, Pull-down list.</i>	200 words.

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	1: Yes 2: No 3: Not Applicable	
Vendor changes	<i>Single, Pull-down list.</i> 1: Yes 2: No 3: Not Applicable	200 words.
Other	<i>Single, Pull-down list.</i> 1: Yes 2: No 3: Not Applicable	200 words.

5.1.3 Does Applicant routinely subcontract any significant portion of its operations or partner with other companies to provide health plan coverage? If yes, identify which operations are performed by subcontractor or partner and provide the name of the subcontractor.

	Response	Conducted outside of the United States?	Description
Billing, invoice, and collection activities	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Database and/or enrollment transactions	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Claims processing and invoicing	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Membership/customer service	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Welcome package (ID cards, member communications, etc.)	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Other (specify)	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.

5.2 Implementation Performance

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

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5.2.1 Applicant must complete Attachment B_QHP-QDP-IND-CCSB_Implementation Organizational Chart.

Single, Radio group.

1: Attached

2: Not attached

5.2.2 Applicant must describe a detailed implementation plan. If Applicant is currently operating in Covered California, Applicant must explain if there are new systems being implemented. If Applicant is currently operating in Covered California and there are no new updates, Applicant must indicate there are no new updates.

500 words.

5.2.3 Applicant must submit a detailed Renewal and Open Enrollment Readiness plan. Applicant must include in their plan a timeline with dates for communications (regulated and marketed), system and website updates and readiness, and trainings for staff and agents.

Single, Radio group.

1: Attached [500 words]

2: Not attached, [500 words]

5.2.4 Applicant must describe current or planned procedures for managing new Covered California Enrollees. Applicant must address availability of customer service prior to coverage effective date, and new member orientation services and materials.

200 words.

5.2.5 Applicant must identify the percentage increase of membership that will require adjustment to Applicant's current resources, describe what resource adjustments will be made for the increased membership and how it will be monitored.

Resource	Membership Increase (as % of Current Membership)	Resource Adjustment (specify)	Approach to Monitoring
Members Services	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Claims	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Account Management	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Clinical staff	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Disease Management staff	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Implementation	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Financial	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>

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Administrative	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Actuarial	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Information Technology	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>
Other (List)	<i>Percent.</i>	<i>100 words.</i>	<i>100 words.</i>

5.2.6 Applicant must provide a detailed description of their policy to validate provider information during initial contracting and when a provider reports a change (including demographic information, address, and network or panel status).

200 words.

6 Customer Service

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

6.1 Applicant must confirm it will respond to and adhere to the requirements of California Health and Safety Code Section 1368 relating to consumer grievance procedures and maintain an internal review process to resolve a consumer's written or oral expression of dissatisfaction.

Single, Radio group.

1: Confirmed

2: Not confirmed

6.2 Covered California operating hours are 8 AM to 6 PM Monday through Friday (except holidays).

Applicant must confirm it will match Covered California Open Enrollment Customer Service operating hours.	<i>Single, Radio group.</i> 1: Confirmed 2: Not confirmed
Describe how Applicant will modify customer service center operations to meet Covered California-required operating hours, if hours are not currently matched.	<i>100 words.</i>
Describe how Applicant will modify its current Interactive Voice Response (IVR) system to meet Covered California required operating hours, if applicable.	<i>100 words.</i>

6.3 Applicant must list internal daily monitored Service Center Statistics.

Daily Service Center Statistic	Monitored	Daily Service Level Goal (i.e., 80% of calls answered within 30 seconds)
Total Inbound Calls	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>50 words.</i>
Total Calls Answered	<i>Single, Pull-down list.</i>	<i>50 words.</i>

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	1: Yes 2: No	
Total Abandon Calls	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Average Handle Time	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Average Speed to Answer	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Abandonment Rate	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Adherence Staff	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.
Daily Service Level	<i>Single, Pull-down list.</i> 1: Yes 2: No	50 words.

6.4 Applicant must describe the process for staffing the Service Center for teams that support Covered California business, and for providing service center goals and metrics.
100 words.

6.5 Applicant must indicate which of the following training modalities, training tools, and resources are used to train new Customer Service Representatives, select all that apply:

Multi, Checkboxes.

- 1: Instructor-Led Training Sessions
- 2: Virtual Instructor-Led Training Sessions (live instructor in a virtual environment)
- 3: Video Training
- 4: Web-Based training (not Instructor-Led)
- 5: Self-led Review of Training Resources
- 6: Case-Study
- 7: Roleplaying
- 8: Shadowing
- 9: Observation
- 10: Pre-tests
- 11: Post-tests
- 12: Training Evaluations
- 13: Other, describe: [50 words]

6.6 Applicant must describe their Customer Service Representative training program.

What is the length of the entire training period for new Customer Service Representatives?	<i>100 words.</i>
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What information is covered in the training? (i.e. systems training, health care basics, and customer service skills training.)	100 words.
What is the total time from point of hire to completion of training and release to work independently.	100 words.
How frequently are refresher trainings provided to all Customer Service Representatives?	100 words.
What trainings are used to focus on skills improvement as well as training resulting from changes to policy and procedures.	100 words.

6.7 Applicant must indicate languages spoken by Customer Service Representatives, and the number of certified bilingual Representatives who speak each language. Do not include languages supported only by a language line.

Language	Response	Number of Certified Bilingual Representatives
Arabic	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Armenian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Cambodian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Cantonese	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
English	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Farsi	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Hmong	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Korean	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Loa	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Mandarin	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Russian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>

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Spanish	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Tagalog	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Vietnamese	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Integer.</i>
Other, specify	<i>20 words.</i>	<i>Integer.</i>

6.8 Does Applicant use language line to support consumers that speak languages other than those spoken by Customer Service Representatives? Which language line vendor is contracted for support?
Single, Radio group.

1: Yes, specify vendor: [20 words]

2: No

6.9 Applicant must describe any modifications to equipment, technology, consumer self-service tools, staffing ratios, training content and procedures, quality assurance program (or any other items that may impact customer experience) that may be necessary to provide quality service to Covered California consumers.

100 words.

6.10 Applicant must indicate what information and tools are utilized to monitor consumer experience, select all that apply:

Multi, Checkboxes.

1: Customer Satisfaction Surveys

2: Monitoring Social Media

3: Monitoring Call Drivers

4: Common Problems Tracking

5: Observation of Representative Calls

6: Other, describe: [50 words]

7: Applicant does not monitor consumer experience

6.11 Applicant must list all Customer Service Representative Quality Assurance metrics used for scoring of monitored call, include how many calls per Representative, per week are scored. Score card metrics must include:

- Caller Connection
- Communication
- Issue identification and Resolution
- Call Management
- System Issues

200 words.

6.12 Applicant must confirm that to the extent it provides information that is critical for obtaining health insurance coverage or access to health care services through its QHPs, as defined by 45 CFR § 156.250, it will do so in accordance with the accessibility standards described in 45 CFR § 155.205(c).

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Single, Radio group.

1: Confirmed

2: Not confirmed

6.13 Applicant must briefly describe its process for providing information to consumers and enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and for individuals who have limited English proficiency.

200 words.

7 Sales Channels

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level.

7.1 Covered California expects Applicants to contract with Insurance Agents or General Agencies (also referred to as Insurance Brokers or Producers). If certified, Applicant must confirm it will work with Insurance Agents or General Agencies and will be in compliance with the requirements in the contract with Covered California.

Single, Radio group.

1: Confirmed

2: Not confirmed

7.2 Applicant must submit its Producer Agreement document as an attachment. If Applicant is a new entrant and does not have a Producer Agreement document, Applicant must explain why.

Single, Radio group.

1: Attached

2: Not attached, [200 words]

7.3 Applicant must submit its Agent of Record (AOR) policy and procedures document A Producer Guide, broker compensation schedule, or producer agreement does not satisfy this requirement. If Applicant is a new entrant and does not have an Agent of Record (AOR) policy and procedures document, Applicant must explain the process in development. If Applicant is currently contracted and there are no changes, Applicant may indicate "Currently contracted, no changes to current policy and procedures". Review the Covered California Agent Delegation Policy,

https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf

Single, Radio group.

1: Attached

2: Not attached, [200 words]

7.4 Applicant must provide a description for the following Agent of Record (AOR) Policy and procedures for the Individual market. If Applicant does not currently work with Insurance Agents or General Agencies (also referred to as Insurance Brokers or Producers), Applicant must explain how Applicant will be ready to contract with Insurance Agents or General Agencies for the certification year. If Applicant is currently contracted and there are no changes, Applicant may indicate "Currently contracted, no changes to current policy and procedures". "Not Applicable" is not considered an acceptable response. Review the Covered California Agent Delegation Policy,

https://hbex.coveredca.com/toolkit/PDFs/Delegation_Change_Policy_FINAL.pdf

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	Individual Market – AOR Appointment Policy	Description
Appointment Process	Describe AOR appointment process for agents to be appointed by Applicant. This should include the application, and mandatory requirements, exclusions. Also, include the requirements if the agent is to be appointed with a general agency contracted with Applicant.	100 words.
Timeline	Provide the AOR appointment timeline for agents. Include (1) how the effective date is determined for the new servicing agent, (2) whether the Applicant accepts retroactive AOR appointment requests, (if not, must explain the policy), and (3) the average processing time from submission to approval.	100 words.
AOR Change	Describe the procedure for AOR changes requested by consumers outside of the 834-file process. For example, if the consumer contacts the Applicant directly, what is the Applicant's process?	100 words.
AOR Change	Describe procedures used to manage AOR changes when the change is made via an 834-file.	100 words.
AOR Change	Describe any reasons for which Applicant will not make changes to AOR for an enrollment.	100 words.
Other	Additional comments.	100 words.

7.5 Applicant must confirm it will pay no less than the minimum commission rate set by Covered California each plan year according to the “Covered California Commission Guidance”.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed

7.6 Applicant must provide its current plan year and certification year Agent of Record (AOR) Commission Schedule for the individual market in California and describe the payment format and specify the commission basis.

Applicant must indicate the commission format for each product type using one of the following:

- Flat dollar amount per member per month (\$ PMPM)
- Flat dollar amount per policy per month (\$ per policy/month)
- Percentage of premium (%)
- Tiered structure (by volume, enrollment threshold, or other criteria)

If the commission is tiered, Applicant must describe the full tier schedule, including all volume thresholds and corresponding rates, in the Details row.

If Applicant pays a Field Marketing Organization (FMO) or General Agency (GA) override in addition to base agent commission, Applicant must disclose that amount separately in the Details row.

If the certification year AOR commission is not yet finalized, Applicant must explain why in the Details row and provide the expected date by which the commission schedule will be communicated to agents.

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Product	HMO	PPO	EPO
Plan Year 2027 New (\$ or %)	10 words.	10 words.	10 words.
Certification Year 2028 New (\$ or %)	10 words.	10 words.	10 words.
Plan Year 2027 Renewals (\$ or %)	10 words.	10 words.	10 words.
Certification Year 2028 Renewals (\$ or %)	10 words.	10 words.	10 words.
Commission Basis (PMPM / Per Policy / % of Premium / Tiered)	10 words.	10 words.	10 words.
Plan Year 2027 Tiered Structure	<i>Compound, Pull-down list.</i> 1: Yes, [100 words] 2: No	<i>Compound, Pull-down list.</i> 1: Yes, [100 words] 2: No	<i>Compound, Pull-down list.</i> 1: Yes, [100 words] 2: No
Certification Year 2028 Tiered Structure	<i>Compound, Pull-down list.</i> 1: Yes, [100 words] 2: No	<i>Compound, Pull-down list.</i> 1: Yes, [100 words] 2: No	<i>Compound, Pull-down list.</i> 1: Yes, [100 words] 2: No
FMO / GA Override (if applicable)	10 words.	10 words.	10 words.
Details. If commission rate is TBD, provide expected finalization date	100 words.	100 words.	100 words.

Note: Successful Applicants will be required to use a standardized Agent commission program with levels and terms that result in the same aggregate compensation amounts to Agents, whether products are sold within or outside of Covered California. Successful Applicants may not vary Agent compensation levels by metal tier and must pay the same commission during Open and Special Enrollment for each plan year.

7.7 Applicant must confirm if it offers a bonus program. If yes, Applicant must provide: (1) the estimated total annual cost of the bonus program in California for the current benefit year as a % of premium and in dollars, separated by on-exchange and off-exchange where applicable, and (2) a brief description of the bonus structure (e.g., enrollment-based, retention-based, performance threshold).

Single, Radio group.

- 1: Confirmed, explain [100 words] ,
2: Not confirmed, explain [100 words]

7.8 Applicant must provide the percentage of premium separately	Percent of Premium total commission On Exchange	Percent of Premium total commission Off Exchange	Base Commission	Bonus	Other	Details

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for: (a) On-Exchange – base commission only (excluding bonuses), (b) On-Exchange – total including all bonuses and other financial payments, (c) Off-Exchange – base commission only, (d) Off-Exchange – total including all bonuses and other financial payments. If Applicant does not offer Off-Exchange products in California, Applicant must confirm this explicitly. Product						
HMO	10 words.	10 words.	10 words.	10 words.	20 words.	100 words.
PPO	10 words.	10 words.	10 words.	10 words.	20 words.	100 words.
EPO	10 words.	10 words.	10 words.	10 words.	20 words.	100 words.

7.9 Applicant must provide a detailed description of the following commission terms. If Applicant is currently contracted and there are no changes, Applicant may indicate “Currently contracted, no

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changes to current description on the following commission term". "Not Applicable" is not considered an acceptable response.

	Individual Market - Commission Rate	Description
Payment	Provide the policy on how commissions are paid to AOR for Individual and Family Plans (IFP) plans. What are the exclusions, if any?	100 words.
Payment	Provide the date of payment of commission to an AOR for new member effectuated policies.	100 words.
Payment	Describe any reasons for which Applicant will not compensate agents for an enrollment.	100 words.
Retention Incentives	Describe any retention incentives for the AOR if the agent retains a specified number of members' policies during renewal or over a period of time.	100 words.
Tax ID Changes	Describe the process agents must follow in order to change their payee tax ID with the Applicant in order to continue to receive commission payments.	100 words.
Reconciliation	Describe AOR commission reconciliation and error resolution processes. Include information on how Applicant resolves commission and AOR discrepancies for agents.	100 words.
Other	Additional Comments	100 words.

7.10 Applicant must complete the following table of Individual and Family Plans Sales Team Organizational Chart.

Key Individual Name	Email Address	Phone Number	Geographic Territory
10 words.	10 words.	10 words.	10 words.
10 words.	10 words.	10 words.	10 words.
10 words.	10 words.	10 words.	10 words.

7.11 Agents have become an integral channel of the Applicant's enrollment: Covered California requires Applicant to have an agent services support team to provide communication and sales strategy that assists in facilitating the ease of business. Therefore, part of the strategy requires Applicant to provide support services to the agents who enroll consumers in Applicant's plan product in the Individual and Family Plan market in California. Applicant must provide a description for Agent Services. If Applicant is currently contracted and there are no changes, Applicant may indicate "Currently contracted, no changes to current service and process". "Not Applicable" is not considered an acceptable response.

Sup-Topic	Agent Services	Description
Support Services	Describe your agent support services for your appointed agents/brokers. Include different ways on how an appointed agent/broker can reach out to Applicant for questions and support with their appointment, commissions, client cases, plan information, etc.	100 words.
Support Services	Do you have an agent portal for agents? If yes, describe the portal functionality and capabilities agents have access to.	100 words.

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Support Services	Describe sales and marketing tools or trainings you have available for agents to reach consumers for your enrollment support. Include the sales collateral (hard copy) and online sales tool resources. Include how you disburse these.	100 words.
Communication	Describe your overall communication strategy to agents to share messages, updates, important announcements, and dates impacting the agents' work and their client cases. Include the different types of communication method (email, text, portal, etc.)	100 words.
Sales	Outreach to niche populations: (a) Identify the specific niche or hard-to-reach populations your sales strategy targets. (b) Describe the specific outreach channels and tactics used to reach each population. (c) Identify whether Applicant works with agents, Navigators, CECs, and/or community partners who specialize in serving these populations, and how they are supported.	100 words.
Network Changes	Does the Applicant have an active process for notifying agents of provider network changes? (Yes / No / In Development) If Yes: Describe the frequency, method of notification (email, portal alert, broker newsletter, etc.), and approximate lead time before changes take effect. If No or In Development: Describe the plan and timeline to implement this process.	100 words.
Plan-Based Enrollers	Explain how you utilize Plan-Based Enrollers?	100 words.
Off-Exchange Consumers	What is your current number of off-exchange IFP members?	100 words.
Off-Exchange Consumers	Do you evaluate Off-Exchange members to determine if they qualify for ACA Advanced Premium Tax Credit (APTC)? If an off-exchange member is eligible for APTC, what is your commitment with direct outreach to make them aware of their potential cost-savings?	100 words.
Other	Additional comments.	100 words.

8 Marketing and Enrollment

Questions 8.4 - 8.5 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

8.1 Covered California expects all successful Applicants to promote enrollment in their QHPs and support retention, utilization and member engagement. Applicant must provide an organizational chart of its marketing department(s), including names and titles of the main marketing contacts that will be responsible for marketing their Individual and Family Plans (both on and off exchange).

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Single, Pull-down list.

- 1: Attached
- 2: Not attached

8.2 Applicant must confirm that, upon contingent certification of its QHPs, it will cooperate with Covered California Marketing Department, and adhere to the Covered California Brand Style Guide <https://hbex.coveredca.com/toolkit/logos.html>, and Marketing Guidelines (if applicable) when co-branded materials are issued to Covered California Enrollees. If Applicant is certified, co-branded items must be submitted in a timely manner, but no later than 10 business days before the material is used; ID cards must be submitted to Covered California at least thirty (30) days prior to Open Enrollment.

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

8.3 Applicant must confirm it will coordinate and cooperate with Covered California Marketing, Public Relations, and Outreach efforts, which may include internal and external trainings, press events, social media efforts, collateral materials, member education and communications, and other efforts. This coordination and cooperation obligation includes contractual requirements to submit materials and updates according to deadlines established in the QHP Issuer Model Contract.

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

8.4 Applicant must confirm it will meet marketing investment plan and reports requirements established in the QHP Issuer Model Contract to promote enrollment and support retention, utilization, and member engagement in Individual and Family Plans (on exchange). Applicant may submit any supporting documentation as an attachment. If Applicant cannot confirm it will meet marketing investment plan and reports, Applicant must explain why.

Single, Radio group.

- 1: Confirmed to meet marketing investment plan and reports requirements
- 2: Not confirmed, explain [500 words]

8.5 Applicant must indicate the dollar amount of the total proposed marketing spend Applicant projects allocating to Proposed Marketing Investment in Qualifying Marketing Activities as outlined in the QHP Issuer Model Contract.

Proposed Marketing Investment: Dollars.

9 Privacy and Security Requirements for Personally Identifiable Data

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9.1 HIPAA Privacy Rule

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

Applicant must confirm that it complies with the following privacy-related requirements set forth within Subpart E of the Health Insurance Portability and Accountability Act [45 CFR §164.500 et. Seq.]:

9.1.1 Individual access: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with the opportunity to access, inspect and obtain a copy of any Protected Health Information (PHI) contained within their Designated Record Set [45 CFR §§164.501, 524].

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.1.2 Amendment: Applicant must confirm that it provides enrollees with the right to amend inaccurate or incomplete PHI contained within their Designated Record Set [45 CFR §§164.501, 526].

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.1.3 Restriction Requests: Applicant must confirm that it provides enrollees with the opportunity to request restrictions upon Applicant's use or disclosure of their PHI [45 CFR §164.522(a)].

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.1.4 Accounting of Disclosures: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it provides enrollees with an accounting of any disclosures made by Applicant of the enrollee's PHI upon the enrollee's request [45 CFR §164.528].

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.1.5 Confidential Communication Requests: Applicant must confirm that it permits enrollees to request an alternative means or location for receiving their PHI than what Applicant would typically employ [45 CFR §164.522(b)].

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.1.6 Minimum Necessary Disclosure & Use: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it discloses or uses only the minimum necessary PHI needed to accomplish the purpose for which the disclosure or use is being made [45 CFR §§164.502(b) & 514(d)].

Single, Pull-down list.

1: Confirmed

2: Not confirmed

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9.1.7 Openness and Transparency: Unless otherwise exempted by the HIPAA Privacy Rule, Applicant must confirm that it currently maintains a HIPAA-compliant Notice of Privacy Practices to ensure that enrollees are aware of their privacy-related rights and Applicant's privacy-related obligations related to the enrollee's PHI [45 CFR §§164.520(a)&(b)].

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.2 Information Security

Question 9.2.7 and 9.2.8 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

9.2.1 Applicant must confirm that it has policy, standards, processes, and procedures in place and that its information system is configured with administrative, physical and technical security controls that meet or exceed those standards published in the National Institute of Standards and Technology (NIST), Special Publication 800-53 rev 5, or in the ISO/IEC 27001 that appropriately protect the confidentiality, integrity, and availability of the Protected Health Information (PHI) and Personally Identifiable Information (PII) that it creates, receives, maintains, or transmits.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.2.2 Applicant must confirm that all PHI and PII is encrypted - both at rest and in transit - employing the validated Federal Information Processing Standards (FIPS) 140-compliant encryption standards.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.2.3 Applicant must confirm that it operates in compliance with applicable federal and state security and privacy laws and regulations.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.2.4 Applicant must confirm that it has an incident response policy, process, and procedures in place and can verify that the process is tested at least annually.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

9.2.5 Applicant must confirm that there is a contingency plan in place that addresses system restoration without deterioration of the security measures and that the plan is tested at least annually.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

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9.2.6 Applicant must confirm that when disposing of media containing PHI or PII, they adhere to the guidelines for media sanitization as described in the NIST Special Publication 800-88.

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

9.2.7 Applicant must provide an overview of the Information Security Program. Applicant may submit an attachment. Applicant must provide all relevant information on how PHI and PII are secured within the organization, including but not limited to the following components:

- Information related to governance and policies,
- Risk assessment,
- Security safeguards (technical, physical, and administrative),
- Monitoring and logging,
- Incident response plan,
- Regulatory compliance.

Single, Radio group.

- 1: Explain [1000 words]
- 2: Attached

9.2.8 In the last twelve (12) months has the Applicant experienced a data breach that compromised PHI or PII? If yes, explain the actions taken in response, and any measures implemented to prevent future occurrences.

Single, Radio group.

- 1: No, Applicant did not experience a data breach in the last 12 months
- 2: Yes, and new preventative measures were implemented, explain: [500 words]
- 3: Yes, and no preventive measures were implemented, explain: [500 words]

10 Fraud, Waste, and Abuse Detection

Questions 10.3 and 10.6– 10.8 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

Covered California is committed to working with its QHP Issuers to minimize Fraud, Waste, and Abuse as defined in Section 21 - Glossary. The framework for managing fraud risks is detailed in Appendix A_QHP-QDP-IND-CCSB_GAO-15-593SP (located on the Manage Documents page). Covered California expects QHP Issuers to adopt leading practices outlined in the framework to the extent applicable. Fraud prevention is centered on integrity and expected behaviors from employees and others. All measures to detect, deter, and prevent fraud before it occurs are vital to all issuer and Covered California operations. This Certification ensures that Applicant has policies, procedures, and systems in place to prevent, detect, and respond to fraud, waste, and abuse.

10.1 Applicant must describe the roles and responsibilities of those tasked with carrying out dedicated anti-fraud and fraud risk management activities throughout the organization. If there is a dedicated unit responsible for fraud risk management, describe how this unit interacts with the rest of the

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organization to mitigate fraud, waste, and abuse. Define any acronyms used. “Not Applicable” is not considered an acceptable response.

200 words.

10.2 Applicant must describe anti-fraud strategies and controls including data analytics and fraud risk assessments to circumvent fraud, waste, and abuse. Define any acronyms used. “Not Applicable” is not considered an acceptable response.

200 words.

10.3 Applicant must confirm it will report/refer suspected incidents of fraud, waste and abuse to Covered California per the established Carrier Referral Process and to the appropriate state/federal regulator, government agency, and/or law enforcement agency as required by law. If not, Applicant must provide an explanation.

Single, Radio group.

1: Confirmed

2: Not confirmed, explain: [100 words]

10.4 Applicant must describe policies and procedures it has in place, including details regarding the withholding and subrogation process for recoupment of payments. Define any acronyms used. “Not Applicable” is not considered an acceptable response.

200 words.

10.5 Applicant must describe in detail specific activities it does to identify any violations in the Special Enrollment Period (SEP) policy, the procedures in place to prevent and detect SEP violations, and how the adverse actions are communicated to Covered California? Define any acronyms used. “Not Applicable” is not considered an acceptable response.

200 words.

10.6 Applicant must indicate whether it reviews specified types of providers for possible fraudulent activity related to claims. Applicant must describe the different approaches Applicant takes to monitor the types of providers or provide an explanation why any additional provider types are not being reviewed for fraudulent activity. “Not Applicable” is not considered an acceptable response.

	Response	Description
Hospitals	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Physicians	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Skilled Nursing	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Chiropractic	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>

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Podiatry	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Behavioral Health	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Substance Use Disorder treatment facilities	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Alternative medical care	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Durable medical equipment Providers	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Pharmacy	<i>Single, Radio group.</i> 1: Yes 2: No	<i>200 words.</i>
Other service Providers, specify	<i>50 words.</i>	<i>500 words.</i>

10.7 Based on the definition of Fraud, as defined in Section 21 - Glossary, what was Applicant's recovery success rate and dollars recovered for fraudulent activities for each year below? Applicant must provide an explanation for loss recovery.

	Total Loss from Fraud Covered California book of business.	Total Loss from Fraud Total Book of Business (includes non-Covered California business)	% of Loss Recovered Covered California book of business.	% of Loss Recovered Total Book of Business (includes non-Covered California business)	Total Dollars Recovered Covered California book of business.	Total Dollars Recovered Total Book of Business (includes non-Covered California business)	Description
Calendar Year 2024	<i>Dollars.</i>	<i>Dollars.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>200 words.</i>
Calendar Year 2025	<i>Dollars.</i>	<i>Dollars.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>200 words.</i>
Calendar Year 2026	<i>Dollars.</i>	<i>Dollars.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>200 words.</i>

10.8 Applicant must describe any trends that might contribute to the total loss from fraud for Covered California book of business. Define any acronyms used. "Not Applicable" is not considered an acceptable response.
200 words.

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10.9 Applicant must describe its approach to reviewing claims submitted by non-contracted providers, and steps taken when claims received exceed the reasonable and customary threshold. Define any acronyms used. "Not Applicable" is not considered an acceptable response.

200 words.

10.10 Applicant must describe its approach to the use of the National Practitioner Data Bank as part of the credentialing and re-credentialing process for contracted providers. Describe any additional steps Applicant takes to verify a physician and facility is a legitimate place of business. Define any acronyms used. "Not Applicable" is not considered an acceptable response.

200 words.

10.11 Applicant must describe the fraud controls it has in place to monitor referrals of enrollees to any health care facility or business entity in which the provider may have full or partial ownership or own shares. Attach a copy of the applicable conflict of interest statement. Define any acronyms used. "Not Applicable" is not considered an acceptable response.

Single, Radio group.

1: Attached, [200 words]

2: Not attached, [200 words]

11 Audits

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not product level.

11.1 Applicant must confirm that, if certified, it will agree to subject itself to Covered California for audits and reviews, either by Covered California, or its designee, or other State or Federal regulatory agencies, or their designee. If applicable, audits and reviews may include, but are not limited to:

1. Evaluation of the correctness of premium rate setting,
2. Payments to agents,
3. Questions pertaining to Covered California Enrollee premium payments and Advance Premium Tax Credit payments or state premium assistance payments,
4. Participation fee payments made to Covered California,
5. Applicant's compliance with the provisions set forth in a contract with Covered California,
6. Applicant's internal controls to perform specified duties,
7. Applicant also agrees to all audits subject to applicable State and Federal laws regarding the confidentiality of and release of confidential Protected Health Information (PHI) of Covered California Enrollees.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

12 Electronic Data Interface (EDI)

Questions 12.1 - 12.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

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12.1 Applicant must provide an attachment that includes the following components: An overview of its system, data model, vendors. Any anticipated changes in key personnel and interface partners. If there are no anticipated changes, Applicant must indicate no changes in the attachment.

Single, Radio group.

1: Attached

2: Not attached, describe [100 words]

12.2 Applicant must submit a copy of its system lifecycle and release schedule. Include a summary and details on dependent sub-systems, dependencies, internal and external development team, interaction of vendors, development lifecycle, integration with CalHEERS, interface messaging and testing program.

Single, Radio group.

1: Attached

2: Not attached, describe [100 words]

12.3 Applicant must be prepared and able to engage with Covered California to develop data interfaces between Applicant's systems and Covered California's systems, including the eligibility and enrollment system used by Covered California. Applicant must confirm it will implement systems to accept and generate 834, 999, TA1, and other standard format electronic files for enrollment and premium remittance, and do so in an accurate, consistent, and timely fashion, utilizing the information received and transmitted for its intended purpose.

- See Appendix B_QHP-QDP-IND_EDI 834 Companion Guide for detailed 834 transaction specifications.
- Note: Covered California requires Applicants to sign an industry-standard agreement which establishes electronic information Covered California standards to participate in the required systems testing.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

12.4 Applicant must confirm and describe its ability and experience processing and resolving errors identified by a TA1 file or a 999 file as appropriate and in a timely fashion. Applicant must confirm that it has the capability to accept and complete non-electronic enrollment submissions and changes. Include a statement of capabilities to perform corrective actions.

Single, Radio group.

1: Confirmed, describe: [200 words]

2: Not confirmed, describe: [200 words]

12.5 Applicant must communicate any testing or production changes to system configuration (URL, certification, bank information) to Covered California in a timely fashion.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

12.6 Applicant must be prepared and able to conduct testing of data interfaces with Covered California no later than the beginning of June of the current year and confirms it will plan and implement testing jointly with Covered California to meet system release schedules. Applicant must

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confirm that testing with Covered California will utilize industry security standards: firewall, certification, and fingerprint. Applicant must confirm it will make dedicated, qualified resources available to participate in the connectivity and testing effort.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

12.7 Applicant must describe its ability to produce financial, eligibility, and enrollment data monthly for reconciliation. Standard file requirements and timelines are documented in Appendix C_QHP-QDP-IND_CarrierProcess Guide. Applicant must provide a description of its ability to make system updates to reconcilable enrollment fields on a timely basis and provide verification of completion.

200 words.

12.8 Applicant must confirm and describe how they proactively monitor, measure, and maintain its application(s) and associated database(s) to maximize system response time and performance on a regular basis. Applicant must confirm it can report system status on a quarterly basis.

Single, Radio group.

1: Confirm, describe: [100 words]

2: Not confirmed, describe [100 words]

13 System for Electronic Rate and Form Filing (SERFF)

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level.

13.1 Applicant must confirm to populate and submit all certification year SERFF templates (Rates, Service Area, Plans and Benefits, Network ID, Prescription Drug, Plan ID Crosswalk, Supporting Documentation, and Supplemental URL Submissions) in an accurate, appropriate, and timely fashion listed in Section 1.7 - Key Dates and Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

13.2 Applicant must confirm that it will submit and upload corrections to SERFF within five (5) business days of notification by Covered California, adjusted for any SERFF downtime. Applicant must adhere to amendment language specifications when any item is corrected in SERFF.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

13.3 Applicant must confirm, if certified, it will submit complete and accurate SERFF Templates to Covered California. Covered California will participate in two (2) rounds of validation with the Applicant. Applicant agrees to pay liquidated damages in the amount of \$5,000 for each additional round of validation beyond the first two (2) rounds. Changes to any or all of Applicant's SERFF Templates counts as one (1) round of validation. If instructions provided by Covered California include inaccurate information which necessitates an additional round of validation, or an additional round of

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validation is necessary due to required changes by Covered California or Applicant's State Regulators, those rounds of validation will not be counted in the two (2) rounds of validations.

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

13.4 Applicant must confirm, if certified, it will participate in CalHEERS testing and provide certification of plan data and documents in the CalHEERS pre-production environment. The preproduction environment is the test environment where the parties can validate templates and documents prior to the Renewal and Open Enrollment Periods. Following Applicant's certification of the QHPs in the pre-production environment, any subsequent upload required to correct Applicant's errors in the production environment will result in liquidated damages in the amount of \$25,000. One (1) upload, for purposes of this paragraph, includes all plan data and documents that must be resubmitted to correct Applicant's errors including Summary of Benefits and Coverage, Evidence of Coverage documents. Liquidated damages will not apply to additional uploads resulting from errors in the instructions provided by Covered California, or changes required by Covered California or Applicant's regulator.

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

13.5 Applicant must confirm it will not make any changes to its SERFF templates once submitted to Covered California without providing prior written notice to Covered California, and only if Covered California agrees in writing with the proposed changes.

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

14 Healthcare Evidence Initiative (HEI)

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

To fulfill its mission to ensure that consumers have available the plans that offer the optimal combination of choice, value, quality, and service, Covered California relies on evidence about the enrollee experience with health care. The timely and accurate submission of QHP data is an essential component of assessing the quality and value of the coverage and health care received by Covered California Enrollees. QHP Issuers are required by state law to submit data described by this section. The file layout which details current expectations of requested data is available for review on the Manage Documents page as Appendix H_QHP-IND-CCSB_HEI Extract File Specs. Covered California will consider modifications to the layout when appropriate.

The data elements required to be submitted pursuant to this application, and to the resulting QHP Issuer contract, will include the personal information of enrollees and Applicant's proprietary rate information. Covered California will, and is required by law, to protect and maintain the confidentiality of this information, which shall at all times be subject to the same stringent 350-plus security and privacy-related requirements as other personal information within Covered California's custody or control.

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14.1 Applicant must provide Covered California, through its HEI Vendor, with monthly extracts of all requested detail from applicable claims or encounter records for the following types (both on-Exchange and non-grandfathered off-Exchange). If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H_QHP-IND-CCSB_HEI Extract File Specs, provide a plan and timeline to correct problematic detail and estimate the number and percentage of affected claims and encounters.

Claim / Encounter Type and Applicable Extract Specifications	Response	If No or Yes with deviation, explain.
Professional (using medical claim / encounter specifications)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Institutional (using medical claim / encounter specifications)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Pharmacy (using drug claim specifications)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Drug (non-Pharmacy) (using medical claim / encounter specifications, i.e., for injections, infusions, specialty drugs, and other drugs administered in a medical setting)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Embedded Pediatric Dental covered under Medical Benefits (using medical claim / encounter specifications)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Mental Health (using medical claim / encounter specifications)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Embedded Pediatric Vision covered under Medical Benefits (using medical claim / encounter specifications)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.

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14.2 State law requires QHP Issuers to submit data to Covered California that represents the cost of care. Applicant must provide monthly extracts of complete financial detail for all applicable claims and encounters (both on-Exchange and non-grandfathered off-Exchange). If yes with deviation, explain. If unable to provide all requested financial detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic data elements and estimate the number and percentage of affected claims and encounters. If applicable, address situations in which the QHP Issuer does not currently provide financial details for all or some medical encounters in a capitated arrangement. For example, can or will the Applicant provide a market price or fee-for-service equivalent price so that Covered California's analyses will closely approximate total cost of care?

Financial Detail to be Provided	Response	If No or Yes with deviation, explain.
Submitted Charges	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Allowable Charges	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Copayment	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Coinsurance	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Deductibles	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Plan Paid Amount (Net Payment)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.

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Capitation Financials (per Provider / Facility) <i>Note: If a portion of Applicant provider payments are capitated. If capitation does not apply, select "No" and state "Not applicable, no provider payments are capitated" in the rightmost column.</i>	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
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14.3 Applicant must provide Covered California member IDs, Covered California subscriber IDs, and Social Security Numbers (SSNs) when possible, on all applicable records submitted (on-Exchange and non-grandfathered off-Exchange). In the absence of other Personally Identifiable Information (PII), these elements are critical for Covered California to generate unique encrypted member identifiers linking eligibility to claims and encounter data, enabling Covered California to follow the health care experience of each de-identified member, even if he or she moves from one plan to another or between on- and off-Exchange.

Detail to be Provided	Response	If No or Yes with deviation, explain.
Covered CA Member ID	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Covered CA Subscriber ID	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Member and Subscriber SSN	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	200 words.

14.4 Applicant must supply dates, such as starting date of service, in full year / month / day format to Covered California for data aggregation. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic dates and estimate the number and percentage of affected enrollments, claims, and encounters.

PHI Dates to be Provided in Full Year / Month / Day Format	Response	If No or Yes with deviation, explain.
Member / Patient Date of Birth	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Member / Patient Date of Death	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Starting Date of Service	<i>Single, Pull-down list.</i> 1: Yes	50 words.

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	2: Yes, with deviation 3: No	
Ending Date of Service	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.

14.5 Applicant must supply all applicable Provider Tax ID Numbers (TINs), National Provider Identifiers (NPIs), National Council for Prescription Drug Programs (NCPDP) Provider IDs (pharmacy only), and descriptive codes for individual providers. If yes with deviation, explain. If unable to provide all requested detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic Provider IDs and descriptive codes and estimate the number and percentage of affected providers, claims, and encounters.

Provider IDs and Descriptive Codes to be Supplied	Response	If No or Yes with deviation, explain.
TIN	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
NPI	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
NCPDP	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
American Medical Association (AMA) Health Care Provider Taxonomy Code	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.

14.6 Applicant must provide detailed coding for diagnosis, procedures, etc. on all claims for all data sources. If yes with deviation, explain. If unable to provide all requested coding detail as outlined in Appendix H_QHP-IND-CCSB_HEI File Extract Specs, provide a plan and timeline to correct problematic coding and estimate the number and percentage of affected claims and encounters.

Coding to be Provided	Response	If No or Yes with deviation, explain.
Diagnosis Coding	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	50 words.
Procedure Coding (CPT, HCPCS)	<i>Single, Pull-down list.</i> 1: Yes	50 words.

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	2: Yes, with deviation 3: No	
Revenue Codes (Facility Only)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	<i>50 words.</i>
Place of Service	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	<i>50 words.</i>
NDC Code (Drug Only)	<i>Single, Pull-down list.</i> 1: Yes 2: Yes, with deviation 3: No	<i>50 words.</i>

14.7 Can Applicant or its third-party affiliate (e.g., Pharmacy Benefit Manager) submit all data directly to Covered California? Explain “No” responses, “Yes” responses with deviation, and “Yes” responses which rely on a third party to submit data to Covered California on the QHP Issuer's behalf.

Single, Radio group.

1: Yes

2: Yes, with deviations or any third-party involvement: [50 words]

3: No, explain: [50 words]

15 Health Equity and Quality Transformation

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract delineates Covered California's vision for reform and serves as a roadmap for delivery system improvements. Beginning with the 2017 QHP Issuer Contract, QHP Issuers have been engaged in supporting existing quality improvement initiatives and programs that are sponsored by other major purchasers including the Department of Health Care Services (DHCS), the California Public Employees' Retirement System (CalPERS), the Purchaser Business Group on Health (PBGH), and CMS. These requirements are reflected in the 2023-2025 QHP Issuer contract and have been revised and enhanced in the 2026-2028 QHP Issuer contract. QHP certification and participation in Covered California will be conditional on Applicant developing a multi-year strategy, and reporting year-to-year activities and progress on each of the initiative areas below.

15.1 Certification Requirements

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level. Questions 15.1.1-15.1.4 will be used to assess Applicant's current accreditation status as well as any recognition or accreditation of other health programs and activities (e.g., case management, wellness promotion, etc.).

Contracted QHP Issuers must have Health Plan Accreditation by the National Committee for Quality Assurance (NCQA). Covered California strongly recommends that new entrant Applicants not accredited by NCQA begin the pre-NCQA accreditation process immediately to become accredited by NCQA.

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15.1.1 Applicant must provide proof of accreditation by uploading a copy of the accrediting agency's certificate, naming the file as: "[NCQA, URAC, or AAAHC] Accreditation," and entering the expiration date of the accreditation achieved.

For NCQA Health Plan Accreditation, the Exchange line of business is separate from the Commercial line of business. The NCQA Health Plan Accreditation certificate must indicate the Exchange line of business, the product (HMO, EPO, or PPO), and the expiration date. Acceptable NCQA Health Plan Accreditation statuses are Accredited, Accredited – Interim, Accredited – Provisional, Accredited – Under Review by NCQA, Accredited – Under Corrective Action, Accredited – Appealed by Organization, and Accredited – Merger Review in Process.

New entrant Applicants and Contracted QHP Issuers that recently first contracted with Covered California, that are not accredited must become accredited within 12 months of submitting their initial application for QHP Certification or no later than 90 days before the second Open Enrollment Period that the new entrant's product is offered. To meet contractual requirements, QHP Issuers must achieve and maintain NCQA Health Plan Accreditation.

Indicate all that apply.

Multi, Checkboxes.

- 1: NCQA Health Plan Accreditation: [To the day] , Certificate attached must include NCQA Health Plan Accreditation status
- 2: Utilization Review Accreditation Commission (URAC) Marketplace Health Plan Accreditation: [To the day] , Certificate attached
- 3: Accreditation Association for Ambulatory Health Care (AAAHC): [To the day] , Certificate attached
- 4: Not accredited

15.1.2 If Applicant reported a provisional, interim, in process, or scheduled status for any accreditation or current Utilization Review Accreditation Commission (URAC) or Accreditation Association for Ambulatory Health Care (AAAHC) accreditation in 15.1.1, Applicant must submit a workplan to achieve NCQA Health Plan Accreditation. This workplan may include any pre-accreditation or other improvement steps recommended by the accrediting agency and be coordinated with the NCQA pre-accreditation process. The workplan must be uploaded as a file with the file name "Accreditation Workplan."

Multi, Checkboxes.

- 1: Yes, Accreditation Workplan attached
- 2: Date of scheduled survey for NCQA Health Plan Accreditation: [To the day]
- 3: Not attached
- 4: Not applicable

15.1.3 If Applicant is accredited, reports a status of anything other than "Accredited" in any category, loses accreditation, fails to maintain current or up to date accreditation, or is required to submit a corrective action plan (CAP) for any cause, Applicant must submit the CAP received from NCQA. The CAP must remedy any deficiencies and demonstrate incorporation in workplan to achieve and maintain NCQA Health Plan Accreditation. The CAP must include any improvement steps recommended by the accrediting agency and be coordinated with the NCQA pre-accreditation process, if applicable.

Certification Year new entrant Applicants must receive NCQA Health Plan Accreditation within 12 months of submitting the initial application for QHP Certification or no later than 90 days before the second Open Enrollment Period that the new entrant's product is offered.

Certification Year currently contracted Applicants must maintain NCQA Health Plan Accreditation. If currently contracted applicants receive a status other than "Accredited", or are required to submit a corrective action plan for any cause, Applicant must submit the corrective action plan. The corrective action plan should be uploaded as a file with the file name "Accreditation Corrective Action Plan."

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Single, Radio group.

- 1: Yes, Accreditation Corrective Action Plan attached.
- 2: Date of scheduled survey for NCQA Health Plan Accreditation: [To the day]
- 3: Not attached
- 4: Not applicable

15.1.4 Applicant must provide expiration date(s) of other NCQA Program(s) achieved for the QHP(s) proposed for Certification Year. Indicate all that apply.

Multi, Checkboxes.

- 1: Case Management: [To the day]
- 2: Credentialing: [To the day]
- 3: Credentials Verification Organization (CVO): [To the day]
- 4: Disease Management [To the day]
- 5: Health Information Products: [To the day]
- 6: Long-Term Services and Supports (LTSS): [To the day]
- 7: Managed Behavioral Health Organization (MBHO): [To the day]
- 8: Physician and Hospital Quality: [To the day]
- 9: Provider Network: [To the day]
- 10: Utilization Management: [To the day]
- 11: Wellness and Health Promotion: [To the day]
- 12: N/A

15.1.5 Applicant must confirm its compliance with all contractual requirements found in Attachment 1 - Advancing Equity, Quality, and Value, and Attachment 2 - Performance Standards with Penalties of the Covered California 2026-2028 Individual Market QHP Issuer Contract.

Single, Radio group.

- 1: Confirmed, Contracted Applicant compliant with specified contractual requirements
- 2: Confirmed, New Entrant Applicant agrees to meet all specified contractual requirements if certified
- 3: Not Confirmed

15.1.6 Certification Year currently contracted Applicant must indicate if it was subject to any penalties or deficiencies in Attachment 1 - Advancing Equity, Quality, and Value, or Attachment 2 - Performance Standards with Penalties of the Covered California 2023-2025 Individual Market QHP Issuer Contract during Measurement Year 2025?

QHP Issuer Contract Attachment	Was Applicant subject to penalties or deficiencies?	Describe in detail what steps Applicant has taken or is taking to improve its performance?
Attachment 1 - Advancing Equity, Quality, and Value	<i>Single, Radio group.</i> 1: Yes 2: No 3: Not Applicable	200 words.
Attachment 2 – Performance Standards with Penalties	<i>Single, Radio group.</i> 1: Yes 2: No 3: Not Applicable	200 words.

15.1.7 Applicant must confirm it will comply with Quality Rating System (QRS) data submission requirements as specified by CMS.

Single, Pull-down list.

- 1: Confirmed
- 2: Not Confirmed

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15.2 Health Equity and Disparities Reduction

15.2.1 Organizational Commitment to Cultivating a Culture of Health Equity

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level. Applicant must respond to all questions in this section and ensure that its organization is invested in continually advancing health equity practices through assessing workforce representation, identifying and addressing recruitment and hiring barriers, evaluating workforce cultural humility, and maintaining an inventory of required and optional staff and provider trainings related to cultural humility, racial humility, implicit bias, and related topics.

15.2.1.1 Applicant must demonstrate commitment to advancing health equity through assessing alignment between workforce representation and the population served and implement measures to address any identified misalignment. Describe below.

Multi, Checkboxes

- 1: Describe the demographic factors reviewed to assess workforce representation, including, at minimum, race, ethnicity, language, gender, or other demographic characteristics: [100 words],
- 2: Identify the data sources used to assess workforce representation and alignment with the population served: [100 words],
- 3: Describe how misalignment between workforce representation and the population served is identified: [100 words],
- 4: Describe measures implemented to address identified misalignment, including specific examples: [100 words]

15.2.1.2 Applicant must demonstrate commitment to advancing health equity through assessing if recruitment and hiring practices create barriers to qualified applicants from certain groups, especially historically disadvantaged groups and implementing measures to adjust identified recruitment or hiring practices accordingly. Describe below.

Multi, Checkboxes.

- 1: Describe how recruitment and hiring practices are reviewed to identify barriers to qualified applicants from certain groups, specifically historically underserved groups: [100 words],
- 2: Identify the groups or communities considered in the assessment of recruitment and hiring barriers: [100 words],
- 3: Describe how barriers are identified, documented, or evaluated: [100 words],
- 4: Describe measures implemented to adjust recruitment or hiring practices, accordingly, including specific examples: [100 words]

15.2.1.3 Applicant must demonstrate commitment to advancing health equity through assessing workforce cultural humility and implement measures to address any identified gaps in cultural humility. Describe below.

Multi, Checkboxes.

- 1: Describe the method used to assess workforce cultural humility: [100 words],
- 2: Describe how gaps in workforce cultural humility are identified or documented: [100 words],
- 3: Describe measures implemented to address identified gaps in workforce cultural humility, including specific examples: [100 words],
- 4: Demonstrate that assessment and improvement related to workforce cultural humility occur on an ongoing basis: [100 words]

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15.2.1.4 Applicant must demonstrate commitment to advancing health equity by providing staff and provider training and maintaining an inventory about the trainings provided. Describe below.

Multi, Checkboxes.

- 1: Describe staff and/or provider trainings that Applicant provides on cultural humility, racial humility, implicit bias, or other related topics, and maintain an inventory of the trainings provided: [100 words],
- 2: Specify which trainings are required and which trainings are optional: [100 words],
- 3: Identify the intended audience for each training, such as staff, providers, leadership, or other roles: [100 words],
- 4: Includes relevant training details, such as frequency, format, or timing: [100 words]

15.2.1.5 Applicant demonstrates commitment to a culture of advancing health equity in its organizational leadership. Describe below.

Multi, Checkboxes.

- 1: Identify leaders who are designated and held accountable for disparities reduction, describe, including titles and descriptions of roles and responsibilities: [100 words]
- 2: Identify and develop equity champions in the organization, describe, including specific examples: [100 words]
- 3: Obtains executive leadership buy-in to reduce health disparities, describe, including specific examples: [100 words]
- 4: Invest financially in health equity, describe, including specific examples: [100 words]

15.2.1.6 Applicant demonstrates commitment to a culture of advancing health equity in forming and engaging its teams. Describe below.

Multi, Checkboxes.

- 1: Disparities are openly recognized, everyone within the organization is motivated to reduce them, and everyone knows their role in the process, describe: [100 words]
- 2: Obtain provider or medical group buy-in to reduce health disparities, describe: [100 words]
- 3: Recruit a diverse workforce that reflects plan membership, describe: [100 words]
- 4: Provide staff training in unconscious bias or implicit bias, cultural humility or racial humility, data analysis training to identify health disparities or other trainings, describe: [100 words]
- 5: Provide provider training in unconscious bias or implicit bias, cultural humility or racial humility, trauma-informed care or other trainings, describe: [100 words]

15.2.1.7 Applicant demonstrates commitment to a culture of advancing health equity in its community partnerships. Describe below.

Multi, Checkboxes.

- 1: Partners with community-based organizations that serve populations identified for disparity reduction, describe: [100 words]
- 2: Demonstrate commitment to culturally and linguistically appropriate care to patients, staff, and the community, describe: [100 words]
- 3: Conduct external-facing initiatives, programs and projects to promote better community health, specifically addressing health disparities or improvement of community health apart from the health delivery system. Include any evaluation results of the activity or program, if available, describe: [100 words] , Applicant may submit any supporting documentation as an attachment.
- 4: Lead or participate in statewide, regional, or cross organizational initiatives or collaborative efforts to promote and advance health equity. Include any evaluation results of the activity or program, if available, describe: [100 words]

15.2.2 Linking Quality and Equity

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level.

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15.2.2.1 Applicant must describe how it incorporates health equity into quality improvement work across lines of business. If health equity is currently not part of Applicant's quality improvement program, describe how Applicant plans to incorporate health equity into quality improvement work across lines of business, Select all that apply and provide a description.

Multi, Checkboxes.

- 1: Staffing, describe: [100 words]
- 2: Budget, describe: [100 words]
- 3: Initiatives, describe: [100 words]
- 4: Data infrastructure, describe: [100 words]

15.2.2.2 Applicant must identify the sources of data used to gather member race and ethnicity data for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser.

Demographic Data Type	CalPERS	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected,” describe how Applicant intends to collect specified data elements.
Race/Ethnicity	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	100 words.
Specify	10 words.	10 words.	10 words.	

15.2.2.3 Applicant must indicate whether a methodology is used to estimate race and ethnicity for membership who have not self-identified and use the text box to describe how the data is used in quality improvement efforts. Note that this method should not be used to calculate Applicant's race and ethnicity member self-report rate. Select one from the options below.

Single, Radio group.

- 1: Applicant uses the RAND proxy methodology, describe: [100 words]
- 2: Applicant uses another methodology to estimate race and ethnicity, describe: [100 words]
- 3: Applicant does not use a methodology to estimate race and ethnicity, describe: [100 words]

15.2.2.4 Applicant must indicate how race and ethnicity data are used to address quality improvement and health equity and disparities. Select all that apply.

Multi, Checkboxes.

- 1: Assess adequacy of network to meet members' needs
- 2: Calculate quality performance measures by race/ethnicity
- 3: Calculate member experience measures by race/ethnicity
- 4: Identify areas for quality improvement

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- 5: Identify areas for health education/promotion
- 6: Share provider race/ethnicity data with member to support provider selection
- 7: With appropriate protections, share with provider network to support in provision culturally sensitive care
- 8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
- 9: Analyze disenrollment patterns
- 10: Resource allocation decisions
- 11: Develop outreach programs that are culturally sensitive (explain): [100 words]
- 12: Other (explain): [100 words]
- 13: Race/ethnicity data not used for quality improvement or health equity

15.2.2.5 Applicant must identify the sources of data used to gather member preferred written and spoken language data for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser.

Demographic Data Type	CalPERS	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected,” discuss how Applicant intends to collect specified data elements.
Preferred Language (written or spoken)	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	<i>100 words.</i>
Specify	<i>10 words.</i>	<i>10 words.</i>	<i>10 words.</i>	

15.2.2.6 Applicant must indicate how primary language data are used to address quality improvement and health equity and disparities. Select all that apply.

Multi, Checkboxes.

- 1: Assess adequacy of language assistance to meet members' needs
- 2: Calculate quality performance measures by language
- 3: Calculate member experience measures by language
- 4: Identify areas for quality improvement
- 5: Identify areas for health education/promotion
- 6: Share provider language data with member to support provider selection
- 7: With appropriate protections, share with provider network to support in provisioning language assistance and culturally sensitive care
- 8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
- 9: Analyze disenrollment patterns
- 10: Resource allocation decisions
- 11: Develop outreach programs that are culturally sensitive (explain): [100 words]
- 12: Other (explain): [100 words]
- 13: Language data not used for quality improvement or health equity

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15.2.2.7 Applicant must identify the sources of data used to gather member sexual orientation for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser. If member sexual orientation is collected from members, provide response options offered to members in the Description column.

Demographic Data Type	CalPERS	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected,” discuss how Applicant intends to collect specified data elements.
Sexual Orientation	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	Multi, Checkboxes. 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	100 words.
Specify	10 words.	10 words.	10 words.	

15.2.2.8 Applicant must indicate how member sexual orientation data are used to address quality improvement and health equity and disparities. Select all that apply.

Multi, Checkboxes.

- 1: Assess adequacy of network to meet members' needs
- 2: Calculate quality performance measures by sexual orientation
- 3: Calculate member experience measures by sexual orientation
- 4: Identify areas for quality improvement
- 5: Identify areas for health education/promotion
- 6: Share provider LGBTQ+ specialty care data with member to support provider selection
- 7: With appropriate protections, share with provider network to support provision of culturally sensitive
- 8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
- 9: Analyze disenrollment patterns
- 10: Resource allocation decisions
- 11: Develop outreach programs that are culturally sensitive (explain): [100 words]
- 12: Other (explain): [100 words]
- 13: Sexual orientation data not used for quality improvement or health equity

15.2.2.9 Applicant must identify the sources of data used to gather member gender identity for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser. If member gender identity is collected from members, provide response options offered to members in the Description column.

Demographic Data Type	CalPERS	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected,” discuss how Applicant
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				intends to collect specified data elements.
Gender Identity	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	100 words.
Specify	10 words.	10 words.	10 words.	

15.2.2.10 Applicant must indicate how member gender identity data are used to address quality improvement and health equity and disparities. Select all that apply.

Multi, Checkboxes.

- 1: Assess adequacy of network to meet members' needs
- 2: Calculate quality performance measures by gender identity
- 3: Calculate member experience measures by gender identity
- 4: Identify areas for quality improvement
- 5: Identify areas for health education/promotion
- 6: Share provider gender identity data with member to support provider selection
- 7: With appropriate protections, share with provider network to support in provision of culturally sensitive care
- 8: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
- 9: Analyze disenrollment patterns
- 10: Resource allocation decisions
- 11: Develop outreach programs that are culturally sensitive (explain): [100 words]
- 12: Other (explain): [100 words]
- 13: Gender identity data not used for quality improvement or health equity

15.2.2.11 Applicant must identify the sources of data used to gather member disability status for each line of business. The response “enrollment form” pertains only to information passed on by the purchaser. Describe any use of standard screening questions or survey tools used in the Description column.

Demographic Data Type	CalPERS	Medi-Cal	California Commercial Individual and Group (Off-Exchange)	Description If Applicant answered, “data not collected,” discuss how Applicant intends to collect specified data elements.
Disability Status	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: EHR, 5: Health	<i>Multi, Checkboxes.</i> 1: Enrollment form, 2: Member services contact, 3: Member portal, 4: Electronic Health Record (EHR), specify estimated percent of enrollees below, 5: Health Assessments,	100 words.

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	Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	Assessments, 6: Other, specify below, 7: Data not collected, 8: Line of business not offered	6: Other, specify below, 7: Data not collected, 8: Line of business not offered	
Specify	10 words.	10 words.	10 words.	

15.2.2.12 Applicant must indicate how member disability status data are used to address quality improvement and health equity and disparities. Select all that apply.

Multi, Checkboxes.

- 1: Assess adequacy of network and accessibility services to meet members' needs
- 2: Calculate quality performance measures by disability status
- 3: Calculate member experience measures by disability status
- 4: Identify areas for quality improvement
- 5: Identify areas for health education/promotion
- 6: With appropriate protections, share with provider network to support in provision of culturally sensitive care
- 7: Set benchmarks or target goals for reducing measured disparities in preventive or diagnostic care
- 8: Analyze disenrollment patterns
- 9: Develop outreach programs that are culturally sensitive (explain): [100 words]
- 10: Resource allocation decisions
- 11: Other (explain): [100 words]
- 12: Disability data not used for quality improvement or health equity

15.2.2.13 Does Applicant stratify clinical measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified by which demographic factors? Specify the applicable lines of business.

200 words.

15.2.2.14 Does Applicant stratify maternal health measures by demographic factors for disparities identification and intervention efforts? If so, which measures are stratified by which demographic factors? Specify the applicable lines of business.

200 words.

15.2.3 Culturally and Linguistically Appropriate Care

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level.

15.2.3.1 What training or communication on patient language needs and the California Language Assistance Program requirements does Applicant share with network providers?

200 words.

15.2.3.2 Applicant must indicate its threshold languages and percentage of enrollees that selected each applicable threshold language in plan year 2025.

*Chinese is the combination of Cantonese, Mandarin, and Other Chinese Language.

Threshold language	Response	Percent
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Arabic	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Armenian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Cambodian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Chinese*	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
English	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Farsi	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Hindi	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Hmong	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Japanese	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Korean	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Laotian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Mien	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Punjabi	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Russian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Spanish	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Tagalog	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>

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Thai	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Ukrainian	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Vietnamese	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>Percent.</i>
Other, specify	<i>Single, Pull-down list.</i> 1: Yes 2: No	<i>100 words.</i>

15.2.3.3 Applicant must indicate what frequency and format is communicated to enrollees about availability of language assistance services, such as interpretation and translation. Describe Applicant's notification process to enrollees for interpretation and translation services at each point of service (e.g., telephone, in-person appointments, member communications).

200 words.

15.2.3.4 Applicant must indicate additional strategies used to address patient language needs (e.g., matching providers with patients based on language needs). Describe efforts in place to meet patients' language needs.

200 words.

15.3 Behavioral Health

Questions 15.3.5– 15.3.7 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

15.3.1 Applicant must indicate which of the following mechanisms Applicant will use to ensure Covered California Enrollees have timely access to and receive appropriate, evidence-based behavioral health services. Provide one example of each selected mechanism in use. Note: Applicant may include behavioral health provider network reports from its accrediting organization (NCQA, URAC, AAAHC) as a supplemental attachment.

Multi, Checkboxes.

- 1: Efforts to improve the accessibility and timeliness of behavioral health services considering provider availability, capacity, and the unique needs of diverse enrolled populations, describe: [50 words]
- 2: Changes in benefits management, describe: [50 words]
- 3: Changes to provider networks, describe: [50 words]
- 4: Changes to telehealth service offerings, describe: [50 words]
- 5: Assessment of behavioral health providers' or vendor's language capabilities, describe: [50 words]
- 6: Efforts to improve enrollee education including explanation of point of entry to behavioral health services, describe: [50 words]
- 7: Methods to receive and address Covered California Enrollee concerns, describe: [50 words]
- 8: Other (explain): [100 words]

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15.3.2 Applicant must indicate which of the following methods Applicant uses to monitor and improve the quality, effectiveness, and cultural humility of its behavioral health services. Provide one example of each selected activity.

Multi, Checkboxes.

- 1: Promoting cultural concordance between enrollees and providers, describe: [50 words]
- 2: Monitoring quality measures (HEDIS, PQA, QRS, etc.), describe: [50 words]
- 3: Monitoring patient-reported experience measures (CAHPS, CG-CAHPS, etc.), describe: [50 words]
- 4: Monitoring utilization measures, describe: [50 words]
- 5: Other processes or mechanisms to monitor screening and treatment rates and outcomes not addressed above, describe: [50 words]
- 6: Efforts to support diversification of behavioral health workforce and provider network, describe: [50 words]
- 7: Development of programs for specific cultural settings or populations, describe: [50 words]
- 8: Other (explain): [100 words]

15.3.3 Applicant must indicate the number of behavioral health measures tracked (e.g., clinical measures, patient-reported experience, or others) to ensure enrollees receive appropriate, evidence-based treatment.

Single, Pull-down list.

- 1: No measures are tracked,
- 2: 1,
- 3: 2,
- 4: 3,
- 5: 4,
- 6: 5,
- 7: 6,
- 8: 7,
- 9: 8,
- 10: 9,
- 11: 10,
- 12: 11,
- 13: 12,
- 14: 13,
- 15: 14,
- 16: 15,
- 17: 16,
- 18: 17,
- 19: 18,
- 20: 19,
- 21: 20,
- 22: 21,
- 23: 22,
- 24: 23,
- 25: 24,
- 26: 25

15.3.4 Applicant must specify which measures are tracked (e.g., HEDIS clinical measures, CAHPS patient-reported experience, patient-reported outcome measures, or others) to ensure enrollees receive appropriate, evidence-based behavioral health treatment and provide the results for these measures for measurement year. Indicate whether the measure is used to monitor subcontractor performance in Details. Applicant must provide measure results for its commercial lines of business. If Applicant does not have a commercial line of business, Applicant must provide measure results for its Medi-Cal, California dual Medicaid-Medicare, California Medicare or other state-based exchange line of business. Indicate the line of business in the Details.

Measure	Results - Measurement Year 2026	Details
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1	50 words.	50 words.	100 words.
2	50 words.	50 words.	100 words.
3	50 words.	50 words.	100 words.
4	50 words.	50 words.	100 words.
5	50 words.	50 words.	100 words.
6	50 words.	50 words.	100 words.
7	50 words.	50 words.	100 words.
8	50 words.	50 words.	100 words.
9	50 words.	50 words.	100 words.
10	50 words.	50 words.	100 words.
11	50 words.	50 words.	100 words.
12	50 words.	50 words.	100 words.
13	50 words.	50 words.	100 words.
14	50 words.	50 words.	100 words.
15	50 words.	50 words.	100 words.
16	50 words.	50 words.	100 words.
17	50 words.	50 words.	100 words.
18	50 words.	50 words.	100 words.
19	50 words.	50 words.	100 words.
20	50 words.	50 words.	100 words.
21	50 words.	50 words.	100 words.

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22	50 words.	50 words.	100 words.
23	50 words.	50 words.	100 words.
24	50 words.	50 words.	100 words.
25	50 words.	50 words.	100 words.

15.3.5 Applicant must describe efforts undertaken to implement and increase the use of patient-reported outcome measures, such as those based on the use of standardized screening and follow-up tools for depression, anxiety, and substance use disorders by primary care and behavioral health providers.

200 words.

15.3.6 Applicant must describe follow-up services offered for adult enrollees who are receiving specialty mental health or substance use disorder (SUD) services.

Note: Specialty mental health services refers to a higher level of care than is generally provided in a general primary care setting for the care of mild to moderate mental health conditions. Specialty mental health services may include care delivered with a specific area of focus (e.g. eating disorders).

100 words.

15.3.7 Applicant must describe the follow-up protocol for an emergency department visit for adult enrollees receiving specialty mental health or substance use disorder services in the past year (e.g., counseling, medication, other services).

Note: Specialty mental health services refers to a higher level of care than is generally provided in a general primary care setting for the care of mild to moderate mental health conditions. Specialty mental health services may include care delivered with a specific area of focus (e.g. eating disorders).

100 words.

15.4 Health Promotion and Prevention

Questions 15.4.1 and 15.4.2 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

15.4.1 Applicant must identify enrollee interventions used in Plan Year 2026 to improve immunization rates. Select all that apply.

	Response	Details
Childhood Immunizations	Multi, Checkboxes. 1: Expanded access for pediatric well-child visits and/or vaccines, including extended clinic hours, mobile vans, or transportation support 2: Workforce supports, such as temporary staff dedicated to vaccine counseling or delivering immunizations, or community health workers supporting people in attending	200 words.

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	appointments, 3: Pharmacy supports such as enhanced pharmacy hours, pharmacist training to support vaccine counseling 4: Communication and outreach interventions. Communication interventions may include evidence-based vaccine communication training for clinical team members. For outreach interventions, please distinguish between reminders sent based on general eligibility (age/gender) versus, enrollee-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone, or live outbound telephone calls triggered by the absence of a service), 5: Local / regional or community-specific interventions such as partnerships with local schools or community-based organizations working with populations of focus including collaborating during local events or health fairs. 6: Enrollee incentives, describe 7: Provider incentives, describe 8: Other, describe 9: None of the above	
Immunizations for Adolescents	Multi, Checkboxes. 1: Expanded access for well-child visits and/or vaccines, including extended clinic hours, mobile vans, or transportation support 2: Workforce supports, such as temporary staff dedicated to vaccine counseling or delivering immunizations, or community health workers supporting people in attending appointments 3: Pharmacy supports such as enhanced pharmacy hours, pharmacist training to support vaccine counseling 4: Communication and outreach interventions. Communication interventions may include evidence-based vaccine communication training for clinical team members. For outreach interventions, please distinguish between reminders sent based on general eligibility (age/gender) versus, enrollee-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone, or live outbound telephone calls triggered by the absence of a service), 5: Local / regional or community-specific interventions such as partnerships with local schools or community-based organizations working with populations of focus including collaborating during local events or health fairs 6: Enrollee incentives, describe 7: Provider incentives, describe 8: Other, describe 9: None of the above	200 words.
Immunizations for Adults	Multi, Checkboxes. 1: Expanded access for preventive care visits and/or vaccines, including extended clinic hours, mobile vans, or transportation support 2: Workforce supports, such as temporary staff dedicated to vaccine counseling or delivering immunizations, or community health workers supporting people in attending appointments 3: Pharmacy supports such as enhanced pharmacy hours, pharmacist training to support vaccine counseling 4: Communication and outreach interventions. Communication interventions may include evidence-based vaccine communication training for clinical team members. For outreach interventions, please distinguish between reminders sent based on general eligibility (age/gender) versus, enrollee-specific reminders for gaps in services based on administrative or clinical information (mail, email/text, automated phone, or live outbound telephone calls triggered by the absence of a service), 5: Local / regional or community-specific interventions such as partnerships with local schools or community-based organizations working with populations of focus including collaborating during local events or health fairs. 6: Enrollee incentives, describe 7: Provider incentives, describe 8: Other, describe 9: None of the above	200 words.

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15.4.2 Applicant must indicate whether it currently participates in the California Immunization Registry (CAIR) (both submitting and receiving data). If yes, include a description of how Applicant uses the data obtained in the registry, e.g., supporting outreach to those with gaps in care or evaluating the effectiveness of provider interventions.

Single, Radio group.

1: Applicant participates in CAIR, describe: [50 words] ,

2: Applicant does not participate in CAIR.

15.4.3 Applicant must indicate how it identifies tobacco-dependent enrollees and the tobacco treatment interventions available to enrollees.

	Response	Details
1. Indicate how Applicant identifies tobacco-dependent enrollees.	Multi, Checkboxes. 1: Plan Health Assessment 2: Employer/Purchaser Health Assessment 3: Plan Personal Health Record 4: Claims/Encounter Data 5: Disease or Care Management 6: Wellness Vendor 7: Other, describe 8: None	200 words.
2. Indicate the tobacco treatment interventions Applicant provides directly to enrollees.	Multi, Checkboxes. 1: Nicotine Replacement Therapy 2: Smoking cessation class or program 3: Smoking cessation counseling via PCP/health coach 4: Medication assisted cessation 5: Enrollee incentives, describe 6: Other, describe 7: None	200 words.
3. Confirm Applicant will provide coverage of tobacco treatment as required under Essential Health Benefits (EHB) and describe any additional tobacco cessation interventions Applicant will offer for enrollees.	Multi, Checkboxes. 1: Applicant provides coverage only for tobacco treatment as required under EHB 2: Applicant provides coverage for tobacco treatment as required under EHB and offers the following additional interventions, describe 3: Applicant does not provide coverage for tobacco treatment	200 words.

15.4.4 All contracted QHP Issuers must provide the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program (DPP), to its eligible Covered California Enrollees. The DPP must be available both in-person and online to ensure Covered California Enrollees have equitable access to these services in the event of service area challenges such as rural location or limited program availability and to allow Covered California Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes). The DPP must be accessible to eligible Covered California Enrollees with limited English proficiency (LEP) and eligible Covered California Enrollees with disabilities. The DPP is covered as a diabetes education benefit with zero cost sharing pursuant to the Patient-Centered Benefit Plan Designs. Contractor's DPP must have pending or full recognition by the CDC for all components, including the Lifestyle Change Program. A list of recognized programs in California can be found at: <https://dprp.cdc.gov/Registry>. Note: Provide

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California commercial individual and group (Off-Exchange) enrollee counts and details on interventions or planned activities.

	Response	Details
1. Indicate how Applicant identifies or will identify eligible enrollees for the Diabetes Prevention Program.	<i>Multi, Checkboxes.</i> 1: Plan Health Assessment 2: Employer/Purchaser Health Assessment 3: Plan Personal Health Record 4: Claims/Encounter Data 5: Disease or Care Management 6: Wellness Vendor 7: Other, describe 8: None	<i>50 words.</i>
2. Indicate how Applicant conducts or will conduct enrollee outreach for the Diabetes Prevention Program.	<i>Multi, Checkboxes.</i> 1: Marketing campaigns (letter, email, text, phone, newsletter, mailer, social media) 2: Open Enrollment materials (welcome kits) 3: Disease or Care Management 4: Member Portal 5: Outreach events 6: Other, describe 7: None	<i>50 words.</i>
3. Indicate how Applicant advertises or will advertise the Diabetes Prevention Program.	<i>Single, Radio group.</i> 1: Internal staff 2: Wellness vendor or contracted group 3: Both	
4. Describe how Applicant monitors and evaluates or will monitor and evaluate the effectiveness of the Diabetes Prevention Program.	<i>50 words.</i>	
California Commercial Individual and Group (Off-Exchange) Enrollees		
5. As of December 2026, the number of California commercial individual and group (Off-Exchange) enrollees eligible for Diabetes Prevention Program.	<i>Integer.</i>	
6. As of December 2026, the percent of California commercial individual and group (Off-Exchange) enrollees eligible for Diabetes Prevention Program. (Calculated as number of California commercial individual and group (Off-Exchange) enrollees eligible for Diabetes Prevention Program divided by total number of California commercial individual and group (Off-Exchange) enrollees ages 18 years and older)	<i>Percent.</i>	
7. As of December 2026, the number of eligible California commercial individual and group (Off-Exchange) enrollees who enrolled in an in-person Diabetes Prevention Program.	<i>Integer.</i>	

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8. As of December 2026, the number of eligible California commercial individual and group (Off-Exchange) enrollees who enrolled in an on-line or virtual Diabetes Prevention Program.	<i>Integer.</i>	

15.4.5 Applicant must describe the strategies it is implementing to ensure its enrollee population is up to date with USPSTF recommendations for clinical preventive health screenings and include a full list of those clinical preventive screenings offered.

100 words.

15.4.6 Applicant must explain how it identify gaps in preventive care among enrollees, and what methods, such as reminders and incentives, are used to encourage participation in preventive health activities.

100 words.

15.5 Population Health Management

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

15.5.1 Health Assessment

15.5.1.1 Applicant must indicate its capabilities supporting Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Select all that apply.

Multi, Checkboxes.

- 1: HA Accessibility: Both online and in print
- 2: HA Accessibility: IVR (interactive voice recognition system)
- 3: HA Accessibility: Telephone interview with live person
- 4: HA Accessibility: Multiple language offerings
- 5: HA Accessibility: HA offered at initial enrollment
- 6: HA Accessibility: HA offered on a regular basis to enrollees
- 7: Applicant does not offer an HA

15.5.1.2 Applicant must indicate its activities supporting Health Assessment (HA) programming (formerly known as Health Risk Assessment-HRA or Personal Health Assessment-PHA). Select all that apply.

	Response
Addressing At-Risk Behaviors	<i>Multi, Checkboxes.</i> 1: At point of HA response, risk-factor education is provided to enrollee based on enrollee-specific risk, e.g., at point of "smoking-yes" response, tobacco treatment education is provided as pop-up, 2: Personalized HA report is generated after HA completion that provides enrollee-specific risk modification actions based on responses, 3: Enrollees are directed to targeted interactive intervention module for behavior change upon HA completion,

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	4: Ongoing push messaging for self-care based on enrollee's HA results ("Push messaging" is defined as an information system capability that generates regular e-mail or health information to the enrollee), 5: Enrollee is automatically enrolled into a disease management or at-risk program based on responses, 6: Care manager or health coach outreach call triggered based on HA results, 7: Enrollee can elect to have HA results sent electronically to personal physician, 8: Enrollee can update responses and track against previous responses
Tracking Health Status	Multi, Checkboxes. 1: HA responses incorporated into enrollee health record, 2: HA responses tracked over time to observe changes in health status, 3: HA responses used for comparative analysis of health status across geographic regions, 4: HA responses used for comparative analysis of health status across demographics

15.5.1.3 As part of total population management and person-centered care, Applicant must describe capability to identify enrollees who are utilizing few or no services each year and engage those members in services as needed. Include description of outreach efforts used to engage these enrollees in care.

	California commercial	Medi-Cal	California dual Medicaid-Medicare
Percent of membership with no claims in Measurement Year 2026	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Description of plan activities to engage members who are non-utilizing	<i>100 words.</i>	<i>100 words.</i>	<i>100 words.</i>

15.5.2 Supporting At-Risk Enrollees

15.5.2.1 Based on the definition of At-Risk Enrollee as defined in Section 21 - Glossary, how does Applicant implement risk-stratified care management (RSCM) (the process of assigning a health risk status to a patient and using the patient's risk status to direct and improve care) to identify and provide early interventions for at-risk enrollees? Applicant must describe in detail the risk factors and conditions used for identification, the sources of data or methodologies applied, and how predictive analytics are utilized in this process.

200 words.

15.5.2.2 Applicant must indicate whether it offers care management programs through a contracted vendor or internal staff and describe each care management program.

Single, Radio group.

1: Applicant offers programs through internal staff, describe each program: [100 words]

2: Applicant offers programs through contracted vendor, describe each program: [100 words]

3: Applicant offers programs through internal staff and contracted vendor, describe each program: [100 words]

15.5.2.3 Applicant must describe outreach and interventions used to ensure at-risk enrollees received needed care for Plan Year 2026.

Response	Details
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Outreach and interventions	<i>Multi, Checkboxes.</i> 1: Live outbound telephonic coaching program 2: Face to face visits 3: Enrollee-specific reminders for due or overdue clinical/diagnostic maintenance services or medication events (failure to refill for example) 4: Online interactive self-management support: "Online interactive self-management support" is an intervention that includes two-way electronic communication between Applicant and the enrollee 5: Self-initiated text or email 6: Interactive IVR 7: Other, describe 8: No outreach or interventions were used	50 words.
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15.5.3 Health-Related Social Needs

Given the strong evidence of the role of social factors like food insecurity, marginal housing, and lack of transportation on health outcomes, addressing health-related social needs ("social needs") is an important step in advancing Covered California's goal to ensure everyone receives the best possible care. Covered California acknowledges the importance of understanding patient health-related social needs – an individual's socioeconomic barriers to health – to move closer to equitable care and seeks to encourage the use of social needs informed and targeted care. As social needs are disproportionately borne by disadvantaged populations, identifying, and addressing these barriers at the individual patient level is a critical first step in improving health outcomes, and reducing health disparities. Identification and information sharing of available community resources is critical to meeting identified member social needs.

15.5.3.1 Applicant must identify the channels it screens enrollees for health-related social needs? If screening varies by line of business, specify the line of business.

Multi, Checkboxes.

- 1: Include social needs screening in member portal, list: [50 words]
- 2: Include social needs screening in health assessments, list: [50 words]
- 3: Conduct social needs screening in select health plan programs, describe enrollee eligibility for these programs: [50 words]
- 4: Require or incentivize network providers to screen, describe: [50 words]
- 5: Other, describe: [50 words]
- 6: No enrollee health-related social needs screening performed or incentivized

15.5.3.2 Applicant must identify all health assessment or screening tools in use. If screening varies by line of business, specify the line of business in Other.

Multi, Checkboxes.

- 1: Accountable Health Communities Health-Related Social Needs Screening Tool
- 2: HealthBegins
- 3: Health Leads
- 4: Income, Housing, Education, Legal Status, Literacy, Personal Safety (IHELLP) Questionnaire
- 5: Medicare Total Health Assessment
- 6: National Academy of Medicine Domains
- 7: PRAPARE
- 8: WellRx
- 9: Your Current Life Situation
- 10: Other, describe: [100 words]
- 11: Not applicable, no enrollee health-related social needs screening performed or incentivized

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15.5.3.3 Applicant must identify which staff or vendor representatives conduct or administer the health assessment or screening tool. Include description of any variation by program or internal workstream. If screening varies by line of business, specify any differences by line of business in response. Indicate “not applicable” if social needs screening not performed or incentivized.

50 words.

15.5.3.4 Applicant must identify what training is provided to staff or network providers who conduct the health assessment or social needs screening? If screening varies by line of business, specify any differences by line of business in response.

Single, Radio group.

1: Training specific to the assessment of screening instrument is provided, describe: [50 words]

2: Internally developed training is provided, describe: [50 words]

3: No training provided

15.5.3.5 Does Applicant require or incentivize contracted providers to use a health assessment or screening tool to identify enrollee's social needs? If applicable, describe. If screening varies by line of business, specify any differences by line of business in response.

Single, Radio group.

1: Yes, require screening, describe: [100 words]

2: Yes, incentivize screening, describe: [100 words]

3: No screening requirements or incentives for contracted providers

15.5.3.6 Does Applicant incentivize provider use of z codes or Longitudinal Observation Identifier Names and Codes (LOINC) terminology for identified social needs?

Multi, Checkboxes.

1: Yes, Applicant incentivizes provider use of z codes, describe: [50 words]

2: Yes, Applicant incentivizes provider use of LOINC codes, describe: [50 words]

3: No, Applicant does not incentivize provider use of z codes

4: No, Applicant does not incentivize provider use of LOINC codes

15.5.3.7 Applicant must describe how social needs data collected from the health assessment or screening tool are used. If screening varies by line of business, specify any differences by line of business.

Multi, Checkboxes.

1: Data linked to enrollee's demographic data, describe: [50 words]

2: Data linked to enrollee's health status, describe: [50 words]

3: Health plan representative refers enrollees to the appropriate social service, describe: [50 words]

4: Vendor representative or platform refers enrollees to the appropriate social service, describe: [50 words]

5: Provider or provider team member refers enrollee to appropriate social service, describe: [50 words]

6: Data not linked to Enrollee's demographic data or health status,

7: No referral made

15.5.3.8 Does Applicant maintain a community resource directory or contract with vendor(s) to provide enrollee referrals that address social needs? If yes, indicate all that apply. If screening varies by line of business, specify any differences by line of business in Other.

Multi, Checkboxes.

1: 211

2: Aunt Bertha

3: Healthify

4: One Degree

5: UniteUs

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6: Other, specify: [20 words]

7: No, Applicant does not maintain a community resource directory or contract with vendor to provide enrollee referrals

15.5.3.9 Does Applicant operate a closed-loop referral tracking system to address enrollee's identified social needs? A closed loop referral tracking is the process of tracking the outcomes of a referral, including whether the enrollee received help through the referral and whether the needs that triggered the referral were addressed. If screening varies by line of business, specify any differences by line of business.

Single, Radio group.

1: Applicant operates a closed-loop referral system to address enrollee social needs, describe: [50 words]

2: Applicant does not operate a closed-loop referral system to address enrollee social needs

15.5.4 Prevention of Algorithmic Bias in Healthcare

The potential for bias in algorithms used in decisions to allocate health care resources is increasingly documented. For example, algorithms using cost and utilization data to assess risk and allocate health care services or other resources will exacerbate existing disparities in access to health care by prioritizing those patient populations utilizing services for receipt of additional support. Processes and systems to identify and address these biases are critical to an equitable population health management strategy and preventing exacerbation of existing health disparities.

Covered California recommends referring to the Chicago Booth Center for Applied Artificial Intelligence Algorithmic Bias Playbook for an explanation of algorithmic bias and steps health care services entities can take to identify and address bias in algorithms in use and implement best practices for use of algorithms. The questions in this section 15.5.4 refer to the Playbook's four step process to address potential bias in algorithms.

References:

Algorithmic Bias Playbook Chicago Booth The Center for Applied Artificial Intelligence

<https://www.chicagobooth.edu/research/center-for-applied-artificial-intelligence/research/algorithmic-bias/playbook>

15.5.4.1 Does Applicant regularly inventory clinical algorithms, artificial intelligence (including Generative AI), or software in use by plan program staff, vendors, or contracted providers for utilization review or management functions?

Single, Radio group.

1: Yes, describe: [100 words]

2: No

15.5.4.2 Does Applicant have a systematic process to routinely evaluate the clinical algorithms, artificial intelligence tools (including Generative AI), or software used by its staff, vendors, or contracted providers to ensure algorithms align with the organization's goals for compliance, bias mitigation, transparency, continuous improvement, and ethical use?

Single, Radio group.

1: Yes, describe: [100 words]

2: No

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15.5.4.3 Does Applicant screen or assess clinical algorithms, artificial intelligence tools (including Generative AI), or software used for utilization review or management functions for bias, including the frequency of assessments and oversight of these processes??

Single, Radio group.

1: Yes, describe: [100 words]

2: No

15.5.4.4 If identified, has Applicant taken steps to improve, suspend, or otherwise remediate the use of biased algorithms, artificial intelligence tools (including Generative AI), or software, such as refining data inputs, implementing fairness audits, or halting deployment?

Single, Radio group.

1: Yes, describe including corrective actions, timelines for resolution, and mechanisms to prevent recurrence: [100 words]

2: No,

3: Not applicable, Applicant does not assess clinical algorithms, artificial intelligence (including Generative AI), or software for bias

15.5.4.5 Has Applicant implemented business processes to prevent future algorithmic bias and to monitor the effectiveness of bias mitigation strategies?

Single, Radio group.

1: Yes, describe including any metrics or benchmarks used: [100 words]

2: No

14.5.4.6 Has Applicant established a formal Governance Structure to oversee the use of artificial intelligence (including Generative AI), algorithms, or software for utilization review or management functions?

Single, Radio group.

1: Yes, describe, including responsible parties and oversight mechanisms: [100 words],

2: No

14.5.4.7 Does Applicant track, test, and document all representative Generative AI use cases for utilization review or management functions within its organization?

Single, Radio group.

1: Yes, describe: [100 words],

2: No

14.5.4.8 Does Applicant communicate to its members when Generative AI is used in written interactive communications about benefits?

Single, Radio group.

1: Yes, describe: [100 words],

2: No

14.5.4.9 Does Applicant communicate to its members if bias or errors affecting member care are identified?

Single, Radio group.

1: Yes, describe: [100 words]

2: No

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15.6 Affordability and Cost

15.6.1 Patient-Centered Information and Support

All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

Full transparency on prices, quality and equity is needed across providers for purchasers to ensure value for their employees, as well as standardized measures of quality, patient experience, appropriateness, and total cost of care. These data sets are invaluable to assess the potential impact of proposed transactions.

Enrollees are empowered to engage in their medical decision-making process when they have access to timely health information. Covered California is committed to ensuring that enrollees have access to 1) provider-specific pricing and cost shares for common inpatient, outpatient, and ambulatory services, 2) pricing and cost share of prescription drugs, 3) member specific real-time understanding of accumulations toward deductibles and out of pocket limits, 4) quality information on network providers, and 5) decision-making tools to inform decisions on appropriate care.

15.6.1.1 Applicant must indicate the quality information available that empowers enrollees when searching for providers based on quality performance in selecting a primary care clinician or elective specialty and hospital providers. Indicate the quality information displayed in Applicant's provider search tools in the table below.

Tool	Quality Information Available	Details
<i>Provider Search</i>	<i>Multi, Checkboxes.</i> 1: Rankings and ratings 2: Patient Experience (CAHPS) 3: Awards and recognitions 4: Accreditations 5: Certifications 6: Other, explain in details	<i>100 words.</i>

15.6.1.2 Applicant must indicate the transparency data available in Applicant's treatment cost estimator for enrollees in the table below.

Tool	Quality Information Available	Details
<i>Provider Cost Estimator</i>	<i>Multi, Checkboxes.</i> 1: In/Out of Network Provider Directory 2: Copays/Coinsurance 3: Deductibles 4: Procedures and Billing Codes 5: Authorization Requirements 6: Average Billed Charge	<i>100 words.</i>

15.6.1.3 Applicant must describe the Applicant promotes access to high-value care by guiding enrollees to clinically effective and cost-efficient options in the most appropriate settings—such as the right provider and care location. For instance, this could include encouraging the use of primary care when appropriate, instead of urgent care or emergency department services.

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100 words.

15.6.1.4 Does Applicant provide a mechanism for enrollees to check prescription drug cost shares?

Single, Radio group.

1: Yes, describe: [50 words]

2: No

15.6.1.5 Does Applicant provide a mechanism for enrollees to compare provider and facility cost variation?

Single, Radio group.

1: Yes, describe: [50 words]

2: No

15.7 Participating in Quality Improvement Collaboratives

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level.

Covered California believes that improving health care quality can only be done through long-term, collaborative efforts that effectively engage and support clinicians, hospitals, health systems, and other providers of care. There are several established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California. The following question addresses Applicant's current involvement in collaborative, quality improvement efforts.

15.7.1 Applicant must identify key quality improvement collaboratives and organizations in which Applicant participates. Describe Applicant's degree and form of engagement, including funding, meeting attendance, advocacy, or other activities.

100 words.

15.8 Data Sharing and Exchange

Questions 15.8.2 and 15.8.3 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the Issuer level, not at the product level.

To improve the quality of care and successfully manage costs, successful Applicants will be required to participate in a Health Information Exchange (HIE) and sign the Data Exchange Framework (DxF) Data Sharing Agreement (DSA) by December 31, 2025, with a goal of enhancing exchange of data along the patient, provider, hospital, and payer continuum. Covered California recognizes the importance of aggregating data across purchasers and payers to more accurately understand the performance of providers that have contracts with multiple health plans. Such aggregated data reflecting a larger portion of a provider, group or facility's practice can potentially be used to support performance improvement, contracting and public reporting. Contracted QHP Issuers must participate in the Integrated Healthcare Association's (IHA) Align.Measure.Perform (AMP) Programs to aggregate data by December 31, 2025. In this section, Applicants will be assessed on the extent to which clinical data exchange is occurring, plans to improve data exchange, and the extent to which they are engaging with other payers and stakeholders to support data aggregation.

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15.8.1 Applicant must describe efforts to improve the routine exchange of timely information and clinical data with providers to support the delivery of high-quality care, including participation in a Health Information Exchange (HIE). Applicant must address each of the following: Initiatives to improve the routine exchange of data to improve the quality of care, such as collecting clinical data to supplement annual HEDIS data collection and self-reported race and ethnicity identity. Any real-time or near real-time actionable data, such as pertaining to Emergency Department visits, the Applicant shares with providers. Whether Applicant provides resources or incentives to providers to participate in HIEs. Describe any data exchange initiatives that enhance health equity with an emphasis on supporting enhanced demographic and social risk factor data capture and facilitation of the exchange of community health resources and information.

200 words.

15.8.2 Applicant must identify the HIE initiatives and statewide or regional initiatives in which it is engaged and explain how it participates.

California HIEs *Indicates HIE(s) that have membership in the California Trusted Exchange Network (CTEN) **Indicates HIE(s) that are designated as a Qualified Health Information Organization (QHIO) ***Indicates participation in both CTEN and QHIO	Applicant HIE participation	Details
Manifest MedEx * (formerly CalIndex)	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate	100 words.
Los Angeles Network for Enhanced Services* (LANES)	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate	100 words.
Orange County Partnership Regional Health Information Organization* (OCPRHIO)	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate	100 words.
San Diego Health Connect*	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate	100 words.

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Orange County Partners in Health HIE***	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate in any HIE.	100 words.
Sac Valley MedShare***	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate in any HIE.	100 words.
Serving Communities HIO**	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate in any HIE.	100 words.
Cozeva**	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate in any HIE.	100 words.
Health Gorilla**	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate in any HIE.	100 words.
Long Health, Inc**	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate in any HIE.	100 words.
Other	Multi, Checkboxes. 1: Applicant receipt of information from HIE(s) 2: Applicant dissemination of information to an HIE(s) 3: Other, explain in details 4: Applicant does not participate in any HIE.	100 words.

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15.8.3 Applicant must provide information regarding the extent of its participation in HIEs.

	Response
Number of individual contracted clinicians that participate in HIEs	<i>Integer.</i>
Percent of individual contracted clinicians that participate in HIEs (Calculated as number of individual clinicians that participate in HIEs divided by total number of individual clinicians contracted with Applicant)	<i>Percent.</i>
Number of contracted hospitals that participate in HIEs	<i>Integer.</i>
Percent of contracted hospitals that participate in HIEs (Calculated as number of hospitals that participate in HIEs divided by total number of hospitals contracted with Applicant)	<i>Percent.</i>
Describe Contractor's activities to promote HIE participation by hospitals and individual clinicians.	<i>75 words.</i>

15.8.4 Applicant must report the aggregate number and percentage of enrollees across all lines of business who accessed the Patient Access Application Programming Interface (API).

	Response
Aggregate number of enrollees across all lines of business accessing the Patient Access API	<i>Integer.</i>
Aggregate percent of enrollees across all lines of business accessing the Patient Access API	<i>Percent.</i>

15.8.5 Applicant must identify the data aggregation initiatives in which it is engaged in to support aggregation of claims or other information across payers and describe its participation.

Multi, Checkboxes.

- 1: Integrated Health Association (IHA) Align Measure Perform (AMP) Commercial HMO and Commercial ACO program
- 2: IHA Encounter Data Initiative
- 3: IHA Cost and Quality Atlas
- 4: IHA Provider Directory Utility (Symphony)
- 5: Cal Hospital Compare
- 6: California Maternity Quality Care Collaborative (CMQCC)
- 7: Other, including any description of participation: [100 words]
- 8: Does not participate in any data aggregation initiatives.

15.8.6 If Applicant does not currently participate in IHA Align. Measure. Perform (AMP) programs, describe the status of Applicant's progress towards participating in such programs.

Single, Radio group.

- 1: N/A, Applicant currently participates in IHA AMP programs
- 2: Does not currently participate in IHA AMP programs, [100 words]

15.8.7 Applicant must provide details on the status of electronic information exchange to notify primary care providers of Admission, Discharge, Transfer (ADT) events for Covered California Enrollees.

	Response
Applicant has a process to support and monitor its contracted hospitals in their implementation of ADT data exchange with primary care providers for its Covered California Enrollees.	<i>Single, Radio group.</i>

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	1: Yes 2: No
Describe actions taken by Applicant to support and monitor its contracted hospitals in their implementation of ADT data exchange with primary care providers for its Covered California Enrollees.	<i>75 words.</i>
Number of hospitals that have implemented ADT notification for Covered California Enrollees.	<i>Integer.</i>
Percent of hospitals that have implemented ADT notification for Covered California Enrollees (Calculated as number of hospitals that have implemented ADT notification for Covered California Enrollees divided by total number of hospitals contracted with Applicant).	<i>Percent.</i>
Describe mechanisms in place to assist those hospitals not yet exchanging ADT data to primary care providers for Covered California Enrollees.	<i>75 words.</i>

16 Health Plan Proposal

All questions are required for all Applicants. All questions should be answered at the Issuer level, not at the product level.

Applicant must submit a health plan proposal in accordance with all requirements outlined in this section.

In addition to being guided by its mission and values, Covered California's policies are derived from the Federal Affordable Care Act, which calls upon the Exchanges to advance "plan or coverage benefits and health care provider reimbursement structures" that improve health outcomes. Covered California seeks to improve the quality of care while moderating cost, directly for the individuals enrolled in its plans, and indirectly by being a catalyst for delivery system reform in partnership with plans, providers, and consumers. With the Affordable Care Act and the range of insurance market reforms that have been implemented, the health insurance marketplace will be transformed from one that has focused on risk selection to achieve profitability to one that will reward better care, affordability, and prevention.

Applicant must submit a standard set of QHPs including all four metal tiers and a catastrophic plan in its proposed rating regions. The QHPs in the standard set must adhere to the certification plan year Patient-Centered Benefit Plan Designs. The same provider network type must be used for each QHP in the standard set of QHPs. Applicant's proposal must include coverage of its entire licensed geographic service area. Applicant may not submit a proposal that includes a tiered hospital, physician, or pharmacy network. Applicants must adhere to Covered California's standard benefit plan designs and the requirements in this section without deviation unless approved by Covered California.

Applicant may submit proposals including the Health Savings Account-eligible High Deductible Health Plan (HDHP) standard design. Health Savings Account-eligible plans may only be proposed at the bronze level in the individual exchange in accordance with the Patient-Centered Benefit Plan Designs. Additionally, Applicant may submit proposals to offer additional QHPs for consideration. The additional QHP offerings proposed must be differentiated by product or network.

The 2014 Payment Parameters rule preamble (78 Fed Reg at 15494) clarifies that an Exchange will be adequately enforcing the requirements of 45 CFR 156.420(b) if a QHP issuer limits the American

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Indian/Alaska Native (AI/AN) zero cost share plan variation to the lowest level QHP in a set of standard QHPs. (A set of standard QHPs refers to a collection of standard QHPs identical except for differences in cost sharing or premium.) Accordingly, Covered California requires Applicant to offer the lowest cost AI/AN zero-cost share plan variation in the standard set of QHPs. This requirement applies to both the standard Bronze Plan Design and the optional Bronze High Deductible Health Plan (HDHP). If the Bronze HDHP is offered at a lower premium than Applicant's standard Bronze Plan, the zero-cost share AI/AN variation of the Bronze HDHP must be offered to consumers instead of the standard Bronze Plan variation. The zero-cost share AI/AN Bronze HDHP variation Evidence of Coverage document should include language to the effect that this plan variation is not eligible for use in conjunction with a Health Savings Account (HSA) or other tax advantages. Applicant may not offer the zero-cost share AI/AN variation at the higher metal levels within the set of QHPs. However, Applicants offering the additional QHPs, that do not include a Bronze Plan, must offer the AI/AN zero-cost share plan variation at the lowest cost in that additional set of QHPs. This requirement does not apply to the limited cost share AI/AN plan variation because the member cost sharing differs depending on the provider sought by the member. Limited cost share AI/AN plan variations must be offered for each QHP.

Applicant must cooperate with Covered California to implement coverage or subsidy programs, including those that complement existing programs that are administered by the Department of Health Care Services (DHCS). These programs include requirements in Welfare and Institutions Code 14102.

16.1 Applicant must certify that its proposal includes all four metal tiers (bronze, silver, gold, and platinum) and catastrophic for each health product it proposes to offer in a rating region. If not, Applicant must describe how it will meet the requirement to offer a product with all metal levels.

Single, Radio group.

- 1: Yes, proposal meets requirements
- 2: No: [500 words]

16.2 Applicant must confirm that it will adhere to Covered California naming conventions for on-Exchange plans and off-Exchange mirror products pursuant to Government Code 100503(f).

Single, Pull-down list.

- 1: Confirmed
- 2: Not confirmed

16.3 Final negotiated and accepted premium rates shall be in effect for coverage effective January 1, 2028. Premium proposals must be submitted in accordance with the Certification Application Submission Guidelines instructions and due date(s). Submission instructions for proposals are subject to change and will be communicated to the Applicants. Premium proposals are considered preliminary and may be subject to negotiation as part of QHP certification and selection process. The final negotiated premium rates must align with the product rate filings that will be submitted to the applicable regulatory agency. Premiums may vary by geographic area, family size, and age as permitted by State law, including the requirements of State Regulators regarding rate setting and rate variation set forth at Health and Safety Code §§ 1357.512 and 1399.855, Insurance Code §§ 10753.14 and 10965.9, 10 CCR § 2222.12 and, as applicable, other laws, rules, and regulations, including, 45 C.F.R. § 156.255(b).

Applicant shall provide, in connection with any negotiation process as reasonably requested by Covered California, detailed documentation on Covered California-specific rate development methodology. Applicant shall provide justification, documentation, and support used to determine rate

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changes, including adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions, and other information that affects Covered California-specific rate development process. Covered California may also request information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy or other healthcare provider costs. This information may be necessary to support the assumptions made in forecasting and may be supported by information from Applicant's actuarial systems pertaining to Covered California-specific account.

Applicant must confirm it will submit complete premium proposals for Individual products; the Unified Rate Review Template (URRT), the Supplemental Rate Review Template (SRRT), Actuarial Memorandum and the Rates Data Template through System for Electronic Rate and Form Filing (SERFF) available at: <https://www.qhpcertification.cms.gov/s/QHP>.

Single, Pull-down list.

- 1: Confirmed templates will be completed and uploaded by the due date
- 2: Not Confirmed templates will not be completed and uploaded by the due date

16.4 Applicant must certify that for each rating region in which it submits a health plan proposal, it is submitting a proposal that covers the entire geographic service area for which it is licensed within that rating region. If entire proposed licensed geographic service area is not offered, Applicant must explain why.

Single, Radio group.

- 1: Yes, health plan proposal covers entire licensed geographic service area;
- 2: No, health plan proposal does not cover entire licensed geographic service area; [100 words]

16.5 Applicant must indicate if it is requesting changes to its licensed geographic service area with the regulator, and if so, submit a copy of the applicable exhibit filed with the regulator.

Single, Radio group.

- 1: Yes, filing service area expansion, exhibit attached
- 2: Yes, filing service area withdrawal, exhibit attached
- 3: No, no changes to service area

16.6 Applicant must indicate the different products it intends to offer on Covered California in the individual market for the certification year. If Applicant is proposing plans with different networks within the same product type, respond for Network 1 under the appropriate product category and respond for Network 2 in the category "Other".

Multi, Checkboxes.

- 1: Existing Covered California Product – Health Maintenance Organization (HMO)
- 2: Existing Covered California Product – Preferred Provider Organization (PPO)
- 3: Existing Covered California Product – Exclusive Provider Organization (EPO)
- 4: Existing Covered California Product – Other Network Type
- 5: New Covered California Product – Health Maintenance Organization (HMO)
- 6: New Covered California Product – Preferred Provider Organization (PPO)
- 7: New Covered California Product – Exclusive Provider Organization (EPO)
- 8: New Covered California Product – Other Network Type

16.7 Applicant must complete all tabs in Attachment L_QHP-IND-CCSB_Contracted Provider Organizations to indicate the contracted provider organizations (Pos) in-network for each of the prospective QHP's proposed products (HMO, PPO, EPO, Other). Attachment L includes the Integrated Healthcare Association's (IHA) list of Pos, with their associated unique IDs, as well as their county and region locations. If not attached, Applicant must provide an explanation.

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Single, Radio group.

1: Attached (confirming provider data is for the certification year)

2: Not attached, explain: [50 words]

17 Health Maintenance Organization (HMO)

17.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

17.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.

Single, Radio group.

1: Confirmed

2: Not confirmed, [200 words]

17.1.2 Applicant must confirm it will comply with the contractual requirement to file an off-exchange plan that includes the benefits and services at the cost-sharing and actuarial cost level described in the Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design. This plan must not have any rate increase or cost attributable to the cost of the cost-sharing reduction program. This plan must be filed with the Applicant's applicable regulator for approval.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

17.1.3 Applicant must confirm all guidelines and due dates will be followed, as listed in Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

17.1.4 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND_Patient-Centered Benefit Plan Design Deviations with all requested deviations, including regulator required deviations. If Applicant is currently contracted, Applicant must include previously approved deviations that Applicant requests to offer again. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval.

Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Single, Pull-down list.

1: Yes, deviations requested, attached.

2: No, no deviations requested

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17.1.5 Covered California encourages Applicant to offer plan products which include all ten (10) Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the coverage year Patient-Centered Benefit Plan Design which includes all ten (10) Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.

Single, Radio group.

1: Yes. Individual market QHPs proposed for coverage year include all ten (10) Essential Health Benefits, explain [50 words] ..

2: No. Individual market QHPs proposed for coverage year does not include all ten (10) Essential Health Benefits, explain [50 words] .

17.1.6 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees, such as the Evidence of Coverage or Policy document.

Single, Radio group.

1: Yes, describe: [100 words]

2: No, describe: [100 words]

17.1.7 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC), or provide Policy language describing proposed health Benefits will follow the requirements in the Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028. Applicant must comply with state and federal laws.

Single, Radio group.

1: Confirmed

2: Not confirmed:

17.2 Benefit Administration

Questions 17.2.17-17.2.18 and 17.2.25-17.2.27 are required for currently contracted Applicants. All questions are required for new entrant Applicants. All questions should be answered at the product level, not at the Issuer level.

17.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit: Activities conducted for consumer education and communication. Oversight conducted for dental quality and network management. If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

1: Offer benefit directly under full-service license: [100 words]

2: Subcontractor relationship: [100 words]

3: Not Applicable

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17.2.2 Applicant must describe how it administers child eye care benefits. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the child eye care benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

1: Offer benefit directly under full-service license: [200 words]

2: Subcontractor relationship: [200 words]

3: Other: [200 words]

17.2.3 Applicant must indicate how it administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.

Single, Radio group.

1: Applicant offers benefit directly under full-service license

2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words]

3: Other, describe: [50 words]

17.2.4 Applicant must describe activities it conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.

200 words.

17.2.5 Applicant must specify how it monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	Monitoring Completed by Applicant or Subcontractor
Provider Network Development	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both
Network Adequacy	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both
Appointment Wait Times	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both
Clinical Quality Performance	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both
Patient Experience	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both

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Cultural and Linguistic Concordance	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both
Referral Process between Physical Health and Behavioral Health Providers	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both
Care Coordination	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both
Virtual Care	<i>Single, Pull-down list.</i> 1: Applicant 2: Subcontractor 3: Both

17.2.6 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.

Single, Radio group.

- 1: NCQA Accredited
2: Not NCQA Accredited, [100 words]

17.2.7 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.

Single, Radio group.

- 1: NCQA Accredited
2: Not NCQA Accredited, [100 words]

17.2.8 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.

Single, Radio group.

- 1: NCQA Accredited
2: Not NCQA Accredited, [100 words]

17.2.9 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.

Single, Radio group.

- 1: NCQA Accredited
2: Not NCQA Accredited, [100 words]

17.2.10 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.

Single, Radio group.

- 1: NCQA Accredited
2: Not NCQA Accredited, [100 words]

17.2.11 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.

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Single, Radio group.

1: NCQA Accredited

2: Not NCQA Accredited, [100 words]

17.2.12 Applicant must describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.

Single, Radio group.

1: NCQA Accredited

2: Not NCQA Accredited, [100 words]

17.2.13 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.

Single, Radio group.

1: NCQA Accredited

2: Not NCQA Accredited, [100 words]

17.2.14 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health virtual care.

Single, Radio group.

1: NCQA Accredited

2: Not NCQA Accredited, [100 words]

17.2.15 Applicant must describe all virtual care point solutions and list vendors used. Report NCQA Virtual Accreditation (Primary Care and Urgent Care) status for all vendors as applicable.

200 words.

17.2.16 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Applicant must describe its ability to support virtual care consultations, either through a contractor or provided by the medical group or provider.

Multi, Checkboxes.

1: Plan does not offer or allow virtual care consultations

2: Virtual care with interactive face to face dialogue (video and audio)

3: Virtual care with interactive dialogue over the phone

4: Virtual care asynchronous store and forward

5: Virtual care mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other

6: Remote patient monitoring

7: e-Consult: provider-to-provider

8: Other (specify): [20 words]

17.2.17 Do cost shares for virtual care services differ from the standard benefit design for that product?

Single, Radio group.

1: No, (no attachment)

2: Yes, Attachment D required

17.2.18 Applicant must confirm if it reimburses providers for virtual care consultations conducted.

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Single, Radio group.

1: Confirmed

2: Not confirmed

17.2.19 Applicant must describe the availability of web or virtual care consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for virtual care. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English.

200 words.

17.2.20 Applicant must describe how it promotes virtual care (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

17.2.21 Specific to behavioral health providers, Applicant must describe how it promotes integration and coordination of care between in-person providers and virtual care providers.

200 words.

17.2.22 Covered California requires contracted QHP Issuers to offer virtual care for behavioral health services. Applicant must indicate whether it offers virtual care for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its virtual care capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Virtual Care Offered	Education Efforts	Details
Applicant offers virtual care for behavioral health services	Multi, Checkboxes. 1: Virtual care for emergency behavioral health offered 2: Virtual care for outpatient behavioral health (not integrated) offered 3: Virtual care for inpatient behavioral health offered 4: Virtual care for integrated primary care and behavioral health offered 5: Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe 6: Other, describe 7: No, Applicant does not offer virtual care for behavioral health services	Multi, Checkboxes. 1: Member welcome packets 2: Educational emails 3: Educational mailings 4: Website notices or information 5: Member portal notices or information 6: Information available through provider directory 7: Member app notices or information 8: Information available through call center 9: Other, describe	200 words

17.2.23 Does Applicant use a behavioral health virtual care vendor?

Single, Radio group.

1: Yes, specify vendor: [20 words]

2: No

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17.2.24 Applicant must describe the referral process for members who are in need of higher levels of behavioral health care (who initiates it, how, etc.) and the support offered. State the access timeline with specific timelines and address both urgent and non-urgent pathways and out-of-network contingencies for members who need higher care levels.

200 words.

17.2.25 Based on the definition of Generative Artificial Intelligence (GenAI) as defined in Section 21 - Glossary, Applicant must describe how it uses Generative Artificial Intelligence (GenAI) to support enrollees.

100 words.

17.2.26 Applicant must report all clinical use cases in which GenAI is used.

200 words.

17.2.27 Applicant must describe their GenAI governance approach.

100 words.

17.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

17.3.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the necessary information to allow cross-network comparisons and evaluations. Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new, or if it already exists in Covered California, and it must include the network name.

Single, Radio group.

1: Attached, Applicant attesting to new network (confirming provider data is for the certification year), [10 words]

2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words]

3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year, [10 words]

4: Not attached, explain [50 words]

17.3.2 Applicant must complete all tabs in Attachment E1_QHP-IND-CCSB_HMO Provider Network Tables, for their HMO Network.

Single, Pull-down list.

1: Attached

2: Not attached

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17.3.3 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name the leasing organization, and state whether or not it has the ability to influence provider contract terms.

Single, Radio group.

1: Applicant contracts and manages network

2: Applicant leases network, describe [500 words]

17.3.4 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The implementing regulations would include regulations relating to consumer access to primary, specialty, behavioral health and hospital care based on enrollee access.

Single, Pull-down list.

1: Confirmed

2: Not Confirmed

17.3.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

Single, Radio group.

1: Confirmed

2: Not Confirmed

17.3.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following:

The collection of race/ethnicity information of the population and providers	100 words.
The collection and publication of practitioner language information	100 words.
The tools or services used to meet the language needs of the population;	100 words.
Provider participation in cultural humility training	100 words.

17.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.

Single, Pull-down list.

1: Confirmed,

2: Not Confirmed

17.3.8 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

Does Applicant offer coverage in a California county or region bordering another state?	<i>Single, Pull-down list.</i> 1: Yes,
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	2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California Enrollees? If yes, explain in detail how this coverage is offered. If not, explain why the coverage is not offered.	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, [200 words], 3: Not Applicable

17.3.9 Applicant must describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California's attention.

100 words.

17.4 Essential Community Provider (ECP)

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant must provide reasonable and timely access for Low-income and Medically Underserved populations in each geographic rating region where Applicant's QHP proposals will provide services, by providing access to Essential Community Providers (ECPs) under criteria specified in this section. Applicants with an integrated delivery structure, as determined by Covered California using criteria in question 17.4.3, may qualify for assessment under an alternative standard.

For the purposes of this Section the following definitions shall apply:

- "Low-income" populations are individuals and families living at or below 200% of Federal Poverty Level.
- "Medically Underserved" populations are defined as:
 1. Individuals with HIV/AIDS,
 2. American Indians and Alaska Natives,
 3. Individuals living in Maternity Care Target Areas, as published by the Health Resources and Services Administration (HRSA),
 4. Individuals living in designated Health Professional Shortage Areas, as published by HRSA,
 5. Individuals living in designated Medically Underserved Areas, as published by HRSA, and
 6. Individuals belonging to designated Medically Underserved Populations, as published by HRSA.
- Essential Community Providers include providers in the following categories:
 1. Entities that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B ("340B Entities").
 2. Entities that participate in the program described in Public Health Service Act § 1927(c)(1)(D)(i)(IV).
 3. Entities that participate in California's Disproportionate Share Hospital (DSH) Program, per the final DSH Eligibility List for the current fiscal year.
 4. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.

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5. Federally Qualified Health Centers.
6. Community Clinics or health centers either licensed as a “community clinic” or “free clinic”, by the State under Health and Safety Code section 1204, subdivision (a), or exempt from licensure under Health and Safety Code section 1206.
7. State-owned family planning service sites or governmental family planning sites not receiving Federal funding under special programs, including Title X of the PHS Act, unless they have lost their status under that section, or sections 340(B) or 1927 of the PHS Act due to violations of Federal law.
8. Pediatric oral services providers.
9. Recipients of the Department of Health Care Access and Information’s Community-Based Organization (CBO) Behavioral Health Workforce Grant Program.
10. Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index.
11. Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index.

Covered California’s published Consolidated Essential Community Provider List is available at:
<http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/>.

17.4.1 Applicant must demonstrate that its QHP proposals meet requirements for provider sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant’s provider network data submission to assess Applicant’s ECP network. All the criteria below must be met.

1. Applicant must demonstrate a mix of ECPs (hospital and non-hospital) reasonably distributed to serve Low-income and Medically Underserved populations; **AND**
2. Applicant must include at least one ECP hospital (including 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county, and children’s hospitals) per each county, or, in counties with more than one geographic rating region, one ECP hospital in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
3. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal Primary care providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor’s QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted primary care ECPs located in each geographic rating region. All primary care ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California’s Consolidated ECP list.
4. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor’s QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted behavioral health ECPs located in each geographic rating region. All behavioral health ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California’s Consolidated ECP list.
5. If Applicant is unable to achieve the sufficiency requirements in question 17.4.1 criteria 3 and 4, Applicant must demonstrate contracts with at least fifteen percent (15%) of 340B non-hospital providers in each applicable geographic rating area where Contractor’s QHPs provide Covered Services to Covered California Enrollees, and provide documentation of good faith efforts Contractor is taking or will take to achieve the sufficiency requirements in question 17.4.1 criteria 3 and 4. Covered California will calculate the percentage of contracted 340B entities located in each geographic rating region. All 340B entity service sites shall be counted

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in the denominator, in accordance with the PY2025_QHP-QDP-IND-CCSB_consolidated ECP list-Final version of Covered California's Consolidated ECP list.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved provider sufficiency and a balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of Low-income and Medically Underserved populations throughout the county that are not served by a single contracted ECP hospital.

Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

17.4.2 Applicant must demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant's provider network data submission to assess Applicant's ECP network. All the criteria below must be met.

1. Applicant must demonstrate the nature, type, and distribution of ECP contracting arrangements in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
2. Applicant must demonstrate a balance of hospital and non-hospital ECPs in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
3. Applicant must demonstrate the extent to which providers are accessible to and provide services that meet the needs of Low-income and Medically Underserved populations.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved a sufficient geographic distribution and balance between hospital and non-hospital requirements.

Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

17.4.3 Alternate standard. If Applicant provides a majority of covered professional services through providers employed by the Applicant or through a single contracted medical group, it may request to be evaluated under the alternate standard. The alternate standard requires the Applicant to provide services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories listed above and demonstrate that it does so in each geographic rating region where the QHP provides services to Covered California Enrollees, either through its own integrated delivery system or by offering a contract to at least one ECP outside of its system in each such category.

Applicant requesting consideration under the alternate standard must demonstrate eligibility through one of the following:

1. Employed Providers
 - a. Majority of covered services are rendered by providers employed by Applicant **AND**

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- b. Majority of Applicant's contracts with participating providers are at risk under capitation
2. Single Contracted Medical Group
 - a. Majority of covered services are rendered by a single contracted medical group **AND**
 - b. Majority of Applicant's provider services are at risk under capitation

Applicant requesting consideration under the alternate standard must submit a written description showing the following:

1. How Applicant's network is designed to ensure reasonable and timely access for Low-income, and Medically Underserved individuals (e.g., 24/7 telephone access); **AND**
2. Tracking quantitative data or efforts Applicant will undertake to measure how Low-income and Medically Underserved individuals are accessing needed health care services (e.g., maps of low-income members relative to 30-minute drive time to providers; survey of low-income members experience such as Consumer Assessment of Healthcare Providers Systems (CAHPS) "Getting Needed Care" survey).

Applicant must produce access maps to demonstrate the extent to which it provides services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories. If existing provider capacity does not meet the above criteria, Applicant may be required to provide additional contracted or out-of-network care. Applicants are encouraged to consider contracting with identified ECPs to provide reasonable and timely access for Low-income, Medically Underserved communities.

Applicant must confirm whether it is requesting evaluation under the alternative ECP standard.

Single, Pull-down list.

1: Confirmed, requesting consideration of alternate standard, explanation, including explanation of alternate standard eligibility, and access maps attached,

2: Not requesting consideration under the alternate standard.

17.5 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Comprehensive Pregnancy and Postpartum Care
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2027 but must review Attachment 1 with the

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understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

17.5.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

17.5.1.1 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Hospital Quality	Multi, Checkboxes. 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data, 4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Hospital Cost	Multi, Checkboxes. 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Additional Criteria	100 words.	100 words.	100 words.	100 words.

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17.5.1.2 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Provider Quality	Multi, Checkboxes. 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Provider Cost	Multi, Checkboxes. 1: Total Cost of Care data, 2: Comparison to other physician or physician groups in geographic area, 3: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Additional Criteria	100 words. Nothing required	100 words. Nothing required	100 words.	100 words.

17.5.2 Advanced Primary Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

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17.5.2.1 Applicant must report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2026 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of enrollees who either selected or were matched with a primary care clinician reported in the Certification Application for 2026 and 2027. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

17.5.2.2 Applicant must report all payment methods used for primary care services and number of providers paid under each category in 2026 in Attachment J_QHP-IND_Run Charts as outlined by the Office of Health Care Affordability (OHCA). If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2026 and 2027, including the payment strategies for the top five (5) physician groups. Report data by product (HMO, PPO, EPO, Other). References: HCP LAN Alternative Payment Model APM Framework: <https://hcai.ca.gov/wp-content/uploads/2026/06/THCE-Data-Submission-Guide-v3.0.pdf>

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

17.5.3 Comprehensive Pregnancy and Postpartum Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to pregnancy and postpartum health.

Applicant must:

- 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section).
- 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals work toward reducing pregnancy and postpartum health disparities in alignment with Department of Health Care Services (DHCS).
- 3) Consider a hospital's NTSV C-section rate, improvement trajectory, and engagement in quality improvement efforts, such as participation in coaching when making maternity hospital contracting decisions. Covered California recognizes that no single measure should determine network participation; however, sustained poor performance without demonstrated improvement must be addressed through contracting terms and corrective actions.

New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for NTSV C-sections compared to vaginal deliveries. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote maternal and newborn health and reduce low-value care.

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Returning Applicants contracted with Covered California for more than one (1) year must report on these payment methodologies in their Certification Application, including the percentage of network hospitals and physicians paid under value-based models that minimize incentives for unnecessary surgical delivery.

Returning Applicants, contracted with Covered California for two (2) or more years, must also demonstrate measurable progress in expanding and strengthening these methodologies across their network.

4) Strategize contracting efforts to stabilize the pregnancy and postpartum workforce by expanding the network to include more midwives and doulas, ensuring patients have the autonomy to share their treatment preferences and goals, actively participating in shared decision-making processes with their care team.

17.5.3.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's pregnancy and postpartum payment requirements, supporting medically necessary, high-value care and reducing low-value care, and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered California for two (2) or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select "Not applicable."

Single, Pull-down list.

1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements,

2: Not confirmed,

3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

17.5.3.2 Applicant must report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2026 in Attachment J_QHP-IND_Run Charts. A list of all California hospitals participating in the MDC can be found here: <https://www.cmqcc.org/about-cmqcc/member-hospitals>. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2024, 2025, 2026 and 2027, if applicable.

Single, Pull-down list.

1: Attached,

2: Not attached

17.5.3.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must adopt and expand value-based payment strategies structured to support medically necessary, high-value care that promotes health, resilience, and disease prevention for the pregnancy and postpartum patient participant and their family with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2026 or in the first year of the QHP certification if after 2026. These value-based payment strategies include: 1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Applicant must report various reimbursement models for deliveries and number of network hospitals and physicians paid using each payment strategy in 2026 in Attachment J_QHP-IND Run Charts. Describe all existing payment models for Pregnant and Postpartum delivery procedures. Specifically, explain how the system for paying providers is structured so that there is no financial incentive for NTSV cesarean sections compared to vaginal births.

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Applicants must enter the percentages reported in the Certification Applications for 2024, 2025, 2026 and 2027, if applicable.

Single, Pull-down list.

1: Attached,

2: Not attached,

3: Not applicable, new entrant Applicant

17.5.3.4 Currently contracted Applicant of two (2) or more years must complete Attachment K1_QHP-IND-CCSB_QIS 1 Work Plan - Comprehensive Pregnancy and Postpartum Care to describe strategies for the delivery of high value care and report any progress made since the last QIS submission. Each question in this application is designed to assess distinct aspects of the Applicant's strategy, performance, and commitment to continuous improvement.

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on cross-references (e.g., "see previous response") or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select "Not applicable."

Address each of the following in the work plan narrative:

- Description of how Hospital Safety Ratings are communicated to enrollees to promote autonomy in decision making.
- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.6% or less.
- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2026.
- Description of the expansion strategy for in-network Doulas and Midwife providers.
- Description of how access to culturally and linguistically appropriate pregnancy and postpartum care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services are communicated and promoted to enrollees.
- Description of how Applicant promotes and encourages all in-network hospitals that provide pregnancy and postpartum health services to use the resources provided by CMQCC and enroll in the CMQCC MDC.
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement.
- Description of how local social support services such as food, housing, and transportation programs and other resources are available to members in need of additional support in the postpartum period.
- Further implementation plans for 2027 including milestones and targets for 2028 and 2029
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

Note: Refer to Appendix M for hospital C-section rates.

Single, Radio group.

1: Attached,

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2: Not attached,

3: Not applicable, currently contracted Applicant with fewer than two (2) years or new entrant Applicant

17.5.4 Hospital Quality, Value, and Patient Safety

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer collaborative approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce wasteful healthcare spending.

Applicant must work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients and contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of enrollees. Applicant will improve quality and cost performance across its contracted hospitals and track and report progress and strategies.

New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for low-value or avoidable services, including hospital-acquired infections (HAIs), readmissions, or other preventable complications. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote patient safety, improve clinical outcomes, and reduce wasteful spending.

Returning Applicants contracted with Covered California for more than one (1) year must report on hospital payment methodologies in their Certification Application, including the percentage of network hospitals reimbursed under models that tie payment to quality, value, and patient safety (e.g., HAIs, readmissions, patient satisfaction).

Returning Applicants contracted with Covered California for two (2) or more years, must also demonstrate measurable progress in expanding and strengthening value-based hospital payment strategies across their network and show collaboration efforts with other QHP issuers to improve hospital safety and reduce hospital-acquired infections.

17.5.4.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's Hospital Quality, Value and Safety requirements, supporting medically necessary, high-value care and reducing low-value care, and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered California for two or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select "Not applicable."

Single, Pull-down list.

1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements,

2: Not confirmed,

3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

17.5.4.2 Applicant must report progress on the adoption of a hospital payment methodologies for each general acute care hospital in its networks that ties payment to quality, value and safety. Report, across all lines of business, excluding Medicare, the percentage of hospital reimbursements tied to quality, value and safety and the metrics applied for performance-based payments in Attachment

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J_QHP-IND Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. "Quality performance" includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, new entrant Applicant

17.5.4.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must report the number and percent of hospitals contracted under the model described in question 17.5.4.2 with reimbursement at risk for quality performance in 2026 in Attachment J_QHP-IND_Run Charts.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not Applicable, new entrant Applicant

17.5.4.4 Currently contracted Applicant of two (2) or more years must complete Attachment K2_QHP-IND-CCSB_QIS 2 Work Plan-Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs
- How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality
- Further implementation plans for 2027 including milestones and targets for 2028 and 2029
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on cross-references (e.g., "see previous response") or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select "Not applicable."

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available resources available to hospitals: CMS Quality Improvement Organization (QIO) Program:

<https://www.cms.gov/medicare/quality/quality-improvement-organizations>

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Health Services Advisory Group (HSAG) Quality Improvement and Innovation for Region 7:

<https://www.hsag.com/en/medicare-providers/hospitals/>

Hospital HAI rates can be reviewed individually at: <http://calhospitalcompare.org/>

Single, Radio group.

1: Attached,

2: Not attached,

3: Not applicable, Applicant contracted for fewer than two (2) years with Covered California

17.6 Cost Containment

17.6.1 Cost Containment for Statewide Spending

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California collaborates closely with the California Department of Health Care Access and Information (HCAI) and the Office of Health Care Affordability (OHCA) to ensure the public interest is served by enabling all Californians to access health care that is not only accessible and affordable but also equitable, of high quality, and universally available. In its role as the state-based marketplace, Covered California actively monitors the advancement toward reduced overall healthcare expenditures across the state and manages strategies for cost containment. In this section, Applicants will be assessed on the degree to which cost growth targets have been incorporated into pricing models and contracting strategies.

17.6.1.1 Applicant must describe strategies in place for cost containment based on OHCA's Health Care Spending Target. For each targeted service category (e.g., facility inpatient, facility outpatient, professional inpatient, professional outpatient, Mental Health and Substance Abuse (MHSA), lab, radiology, specialty pharmacy, prescription drug):

- Name and describe the service category or categories being targeted.
- Provide the specific strategy or strategies used (e.g., network curation, value-based contracting, site-of-care optimization, utilization management, price negotiation, etc.).
- Specify applicable lines of business, noting any differences (e.g., Covered California Individual Market, CCSB, off-Exchange).
- Briefly note progress to date, future targets, how quality is integrated and access preserved, quantifiable metrics (e.g., % reductions, cost trends, quality outcomes), and any key challenges with mitigation approaches.
- Highlight how these strategies reduce costs for members by enabling other levers, such as premium reduction.

200 words.

17.6.1.2 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. Covered California is interested in learning about the Applicant's analysis regarding its own costs, such as identifying the root cause(s) of increasing costs in these areas. For each of these 3 cost drivers, identify and describe the root cause(s) of increasing costs, if identified by Applicant. If Applicant has not identified the root cause(s) of increasing costs in these areas, indicate this below.

Multi, Checkboxes.

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- 1: Identify and describe the root cause(s) for high cost for specialty pharmacy: [200 words].
- 2: Identify and describe the root cause(s) for high cost for ER visits: [200 words].
- 3: Identify and describe the root cause(s) for high cost for ambulance: [200 words].

17.6.1.3 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. For each of these 3 cost drivers, describe any strategies Applicant has implemented to contain cost.

Multi, Checkboxes.

- 1; Describe cost containment strategies for specialty pharmacy: [200 words].
- 2: Describe cost containment strategies for ER visits: [200 words].
- 3: Describe cost containment strategies for ambulance: [200 words].

17.6.1.4 Applicant must describe strategies it has implemented to reduce premiums for members.
200 words.

17.6.2 Cost Containment for Formulary Pricing

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California is concerned with the trend in rising prescription drug costs, as pharmacy trend has outpaced medical trend for several years. These rising prescription drug costs include specialty pharmacy, and compounding increases in costs of generic drugs, which are growing drivers of total cost of care. In this section, Applicants will be assessed on the extent to which value, including cost, access, and clinical outcomes, is considered in the construction of formularies, Pharmacy Benefit Management (PBM) relationships, and delivery of pharmacy services.

17.6.2.1 Applicant must describe strategies to improve member affordability of pharmaceuticals. In the response, include the structure of pharmacy network partners, use of product and service carve-outs, and the application drug price benchmarking tools (e.g., ICER and NADAC). Specify whether and how rebates, spread pricing and comprehensive audit rights are leveraged through fair and competitive contracting practices. Highlight how these strategies reduce costs for members and support long-term value in the pharmacy benefit.

200 words.

17.6.2.2 Applicant must describe how it incorporates value (maximizing outcomes achieved per dollar spent) and cost-effectiveness (relative value of different treatments) in its formulary design. Specify the data sources, evaluation methods (e.g., comparative effectiveness, health outcomes data), and clinical or financial criteria used to inform decisions. If applicable, describe any resulting impacts on formulary structure, tiering, or member affordability. Responses must be specific and demonstrate how value and cost-effectiveness considerations influence actual formulary decisions.

200 words.

17.6.2.3 Applicant must describe strategy for managing specialty pharmacy and biologic therapies, including Glucagon-like peptide-1 (GLP-1) receptor agonists. Include how the strategy supports clinical appropriateness, member affordability, and cost-effective utilization. Describe any use of

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utilization management tools (e.g., prior authorization, step therapy, site-of-care optimization), network design, or contracting arrangements. Where applicable, highlight how these approaches have impacted access, member experience, health outcomes, or total cost of care.

200 words.

17.6.2.4 Does Applicant promote and use biosimilar drugs? If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

17.6.2.5 Does Applicant provide decision support for prescribers and enrollees in selecting appropriate, efficacious, high-value treatments and more cost-effective alternatives when applicable? If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

18 Preferred Provider Organization (PPO)

18.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

18.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.

Single, Radio group.

1: Confirmed,

2: Not confirmed, [200 words]

18.1.2 Applicant must confirm it will comply with the contractual requirement to file an off-exchange plan that includes the benefits and services at the cost-sharing and actuarial cost level described in the Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design. This plan must not have any rate increase or cost attributable to the cost of the cost-sharing reduction program. This plan must be filed with the Applicant's applicable regulator for approval.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

18.1.3 Applicant must confirm all guidelines and due dates will be followed, as listed in Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028.

Single, Pull-down list.

1: Confirmed,

2: Not confirmed

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18.1.4 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND-CCSB_Patient-Centered Benefit Plan Design Deviations with all requested deviations, including regulator required deviations. If Applicant is currently contracted, Applicant must include previously approved deviations that Applicant requests to offer again. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval.

Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Single, Pull-down list.

1: Yes, deviations requested, attached.,

2: No, no deviations requested

18.1.5 Covered California encourages Applicant to offer plan products which include all ten (10) Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the coverage year Patient-Centered Benefit Plan Design which includes all ten (10) Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.

Single, Radio group.

1: Yes. Individual market QHPs proposed for coverage year include all ten (10) Essential Health Benefits, explain [50 words] .,

2: No. Individual market QHPs proposed for coverage year does not include all ten (10) Essential Health Benefits, explain [50 words] .

18.1.6 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees, such as the Evidence of Coverage or Policy document.

Single, Radio group.

1: Yes, describe: [100 words] ,

2: No, describe: [100 words]

18.1.7 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the requirements in Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028. Applicant must comply with state and federal laws.

Single, Radio group.

1: Confirmed,

2: Not confirmed:

18.2 Benefit Administration

Questions 18.2.17-18.2.18 and 18.2.25-18.2.27 are required for currently contracted Applicants. All questions are required for new Applicants. All questions should be answered at the product level, not Issuer level.

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18.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit: Activities conducted for consumer education and communication. Oversight conducted for dental quality and network management. If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

- 1: Offer benefit directly under full-service license: [100 words] ,
- 2: Subcontractor relationship: [100 words] ,
- 3: Not Applicable

18.2.2 Applicant must describe how it administers child eye care benefits. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the child eye care benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

- 1: Offer benefit directly under full-service license: [200 words] ,
- 2: Subcontractor relationship: [200 words] ,
- 3: Other: [200 words]

18.2.3 Applicant must indicate how it administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.

Single, Radio group.

- 1: Applicant offers benefit directly under full-service license,
- 2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words] ,
- 3: Other, describe: [50 words]

18.2.4 Applicant must describe activities it conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.
200 words.

18.2.5 Applicant must specify how it monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	Monitoring Completed by Applicant or Subcontractor
Provider Network Development	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both

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Network Adequacy	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Appointment Wait Times	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Clinical Quality Performance	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Patient Experience	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Cultural and Linguistic Concordance	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Referral Process between Physical Health and Behavioral Health Providers	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Care Coordination	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Virtual Care	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both

18.2.6 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

18.2.7 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

18.2.8 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

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18.2.9 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

18.2.10 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

18.2.11 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

18.2.12 Applicant must describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

18.2.13 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

18.2.14 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health virtual care.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

18.2.15 Applicant must describe all virtual care point solutions and list vendors used. Report NCQA Virtual Accreditation (Primary Care and Urgent Care) status for all vendors as applicable.

200 words.

18.2.16 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Applicant must describe its ability to support virtual care consultations, either through a contractor or provided by the medical group or provider.

Multi, Checkboxes.

1: Plan does not offer or allow virtual care consultations,

2: Virtual care with interactive face to face dialogue (video and audio),

3: Virtual care with interactive dialogue over the phone,

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- 4: Virtual care asynchronous store and forward,
- 5: Virtual care mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other,
- 6: Remote patient monitoring,
- 7: e-Consult: provider-to-provider,
- 8: Other (specify): [20 words]

18.2.17 Do cost shares for virtual care services differ from the standard benefit design for that product?

Single, Radio group.

- 1: No, (no attachment),
- 2: Yes, Attachment D required

18.2.18 Applicant must confirm if it reimburses providers for virtual care consultations conducted.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

18.2.19 Applicant must describe the availability of web or virtual care consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for virtual care. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English.

200 words.

18.2.20 Applicant must describe how Applicant promotes virtual care (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

18.2.21 Specific to behavioral health providers, Applicant must describe how it promotes integration and coordination of care between in-person providers and virtual care providers.

200 words.

18.2.22 Covered California requires contracted QHP Issuers to offer virtual care for behavioral health services. In the following table, Applicant must indicate whether it offers virtual care for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its virtual care capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Virtual Care Offered	Education Efforts	Details
Applicant offers virtual care for behavioral health services	<i>Multi, Checkboxes.</i> 1: Virtual care for emergency behavioral health offered, 2: Virtual care for outpatient behavioral health (not integrated) offered, 3: Virtual care for inpatient behavioral health offered, 4: Virtual care for integrated primary care and	<i>Multi, Checkboxes.</i> 1: Member welcome packets, 2: Educational emails, 3: Educational mailings, 4: Website notices or information, 5: Member portal notices or information,	<i>200 words.</i>

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	behavioral health offered, 5: Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe, 6: Other, describe, 7: No, Applicant does not offer virtual care for behavioral health services	6: Information available through provider directory, 7: Member app notices or information, 8: Information available through call center, 9: Other, describe	
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18.2.23 Does Applicant use a behavioral health virtual care vendor?

Single, Radio group.

1: Yes, specify vendor: [20 words] ,

2: No

18.2.24 Applicant must describe the referral process for members who are in need of higher levels of behavioral health care (who initiates it, how, etc.) and the support offered. State the access timeline with specific timelines and address both urgent and non-urgent pathways and out-of-network contingencies for members who need higher care levels.

200 words.

18.2.25 Based on the definition of Generative Artificial Intelligence (GenAI) as defined in Section 21 - Glossary, Applicant must describe how it uses Generative Artificial Intelligence (GenAI) to support enrollees.

100 words.

18.2.26 Applicant must report all clinical use cases in which GenAI is used.

200 words.

18.2.27 Applicant must describe their GenAI governance approach.

100 words.

18.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

18.3.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the necessary information to allow cross-network comparisons and evaluations. Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new, or if it already exists in Covered California, and it must include the network name.

Single, Radio group.

1: Attached, Applicant attesting to new network (confirming provider data is for the certification year), [10 words] ,

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- 2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words] ,
3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year, [10 words] ,
4: Not attached, explain [50 words]

18.3.2 Applicant must complete all tabs in Attachment E2_QHP-IND-CCSB_PPO Provider Network Tables v1.xlsx, for their PPO Network.

Single, Pull-down list.

- 1: Attached,
2: Not attached

18.3.3 Does Applicant conduct provider negotiations or manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name the leasing organization and state whether or not it has the ability to influence provider contract terms.

Single, Radio group.

- 1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

18.3.4 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The implementing regulations would include regulations relating to consumer access to primary, specialty, behavioral health and hospital care based on enrollee access.

Single, Pull-down list.

- 1: Confirmed,
2: Not Confirmed

18.3.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

Single, Radio group.

- 1: Confirmed,
2: Not Confirmed

18.3.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following:

The collection of race/ethnicity information of the population and providers	100 words.
The collection and publication of practitioner language information	100 words.
The tools or services used to meet the language needs of the population;	100 words.
Provider participation in cultural humility training	100 words.

18.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.

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Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

18.3.8 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

Does Applicant offer coverage in a California county or region bordering another state?	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California Enrollees? If yes, explain in detail how this coverage is offered. If not, explain why the coverage is not offered.	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, [200 words], 3: Not Applicable

18.3.9 Applicant must describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California's attention.

100 words.

18.4 Essential Community Provider (ECP)

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant must provide reasonable and timely access for Low-income and Medically Underserved populations in each geographic rating region where Applicant's QHP proposals will provide services, by providing access to Essential Community Providers (ECPs) under criteria specified in this section. Applicants with an integrated delivery structure, as determined by Covered California using criteria in question 18.4.3, may qualify for assessment under an alternative standard.

For the purposes of this Section the following definitions shall apply:

- "Low-income" populations are individuals and families living at or below 200% of Federal Poverty Level.
- "Medically Underserved" populations are defined as:
 1. Individuals with HIV/AIDS,
 2. American Indians and Alaska Natives,
 3. Individuals living in Maternity Care Target Areas, as published by the Health Resources and Services Administration (HRSA),
 4. Individuals living in designated Health Professional Shortage Areas, as published by HRSA,
 5. Individuals living in designated Medically Underserved Areas, as published by HRSA, and
 6. Individuals belonging to designated Medically Underserved Populations, as published by HRSA.
- Essential Community Providers include providers in the following categories:

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1. Entities that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B (“340B Entities”).
2. Entities that participate in the program described in Public Health Service Act § 1927(c)(1)(D)(i)(IV).
3. Entities that participate in California’s Disproportionate Share Hospital (DSH) Program, per the final DSH Eligibility List for the current fiscal year.
4. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.
5. Federally Qualified Health Centers.
6. Community Clinics or health centers either licensed as a “community clinic” or “free clinic”, by the State under Health and Safety Code section 1204, subdivision (a), or exempt from licensure under Health and Safety Code section 1206.
7. State-owned family planning service sites or governmental family planning sites not receiving Federal funding under special programs, including Title X of the PHS Act, unless they have lost their status under that section, or sections 340(B) or 1927 of the PHS Act due to violations of Federal law.
8. Pediatric oral services providers.
9. Recipients of the Department of Health Care Access and Information’s Community-Based Organization (CBO) Behavioral Health Workforce Grant Program.
10. Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index.
11. Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index.

Covered California’s published Consolidated Essential Community Provider List is available at: <http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/>.

18.4.1 Applicant must demonstrate that its QHP proposals meet requirements for provider sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant’s provider network data submission to assess Applicant’s ECP network. All the criteria below must be met.

1. Applicant must demonstrate a mix of ECPs (hospital and non-hospital) reasonably distributed to serve Low-income and Medically Underserved populations; **AND**
2. Applicant must include at least one ECP hospital (including 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county, and children’s hospitals) per each county, or, in counties with more than one geographic rating region, one ECP hospital in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
3. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal Primary care providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor’s QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted primary care ECPs located in each geographic rating region. All primary care ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California’s Consolidated ECP list.
4. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor’s QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted behavioral health ECPs located in each geographic rating region. All behavioral

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health ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list.

5. If Applicant is unable to achieve the sufficiency requirements in question 18.4.1 criteria 3 and 4, Applicant must demonstrate contracts with at least fifteen percent (15%) of 340B non-hospital providers in each applicable geographic rating area where Contractor's QHPs provide Covered Services to Covered California Enrollees, and provide documentation of good faith efforts Contractor is taking or will take to achieve the sufficiency requirements in question 18.4.1 criteria 3 and 4. Covered California will calculate the percentage of contracted 340B entities located in each geographic rating region. All 340B entity service sites shall be counted in the denominator, in accordance with the PY2025_QHP-QDP-IND-CCSB_consolidated ECP list-Final version of Covered California's Consolidated ECP list.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved provider sufficiency and a balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of Low-income and Medically Underserved populations throughout the county that are not served by a single contracted ECP hospital.

Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

18.4.2 Applicant must demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant's provider network data submission to assess Applicant's ECP network. All the criteria below must be met.

1. Applicant must demonstrate the nature, type, and distribution of ECP contracting arrangements in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
2. Applicant must demonstrate a balance of hospital and non-hospital ECPs in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
3. Applicant must demonstrate the extent to which providers are accessible to and provide services that meet the needs of Low-income and Medically Underserved populations.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved a sufficient geographic distribution and balance between hospital and non-hospital requirements.

Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

18.4.3 Alternate standard. If Applicant provides a majority of covered professional services through providers employed by the Applicant or through a single contracted medical group, it may request to be evaluated under the alternate standard. The alternate standard requires the Applicant to provide

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services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories listed above and demonstrate that it does so in each geographic rating region where the QHP provides services to Covered California Enrollees, either through its own integrated delivery system or by offering a contract to at least one ECP outside of its system in each such category.

Applicant requesting consideration under the alternate standard must demonstrate eligibility through one of the following:

1. Employed Providers
 - a. Majority of covered services are rendered by providers employed by Applicant **AND**
 - b. Majority of Applicant's contracts with participating providers are at risk under capitation
2. Single Contracted Medical Group
 - a. Majority of covered services are rendered by a single contracted medical group **AND**
 - b. Majority of Applicant's provider services are at risk under capitation

Applicant requesting consideration under the alternate standard must submit a written description showing the following:

1. How Applicant's network is designed to ensure reasonable and timely access for Low-income, and Medically Underserved individuals (e.g., 24/7 telephone access); **AND**
2. Tracking quantitative data or efforts Applicant will undertake to measure how Low-income and Medically Underserved individuals are accessing needed health care services (e.g., maps of low-income members relative to 30-minute drive time to providers; survey of low-income members experience such as Consumer Assessment of Healthcare Providers Systems (CAHPS) "Getting Needed Care" survey).

Applicant must produce access maps to demonstrate the extent to which it provides services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories. If existing provider capacity does not meet the above criteria, Applicant may be required to provide additional contracted or out-of-network care. Applicants are encouraged to consider contracting with identified ECPs to provide reasonable and timely access for Low-income, Medically Underserved communities.

Applicant must confirm whether it is requesting evaluation under the alternative ECP standard.

Single, Pull-down list.

1: Confirmed, requesting consideration of alternate standard, explanation, including explanation of alternate standard eligibility, and access maps attached,

2: Not requesting consideration under the alternate standard.

18.5 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

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Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Comprehensive Pregnancy and Postpartum Care
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2027 but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

18.5.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

18.5.1.1 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Hospital Quality	Multi, Checkboxes. 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data, 4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Hospital Cost	Multi, Checkboxes. 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for	100 words.	100 words.

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	hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain		
Additional Criteria	100 words.	100 words.	100 words.	100 words.

18.5.1.2 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Provider Quality	Multi, Checkboxes. 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Provider Cost	Multi, Checkboxes. 1: Total Cost of Care data, 2: Comparison to other physician or physician groups in geographic area, 3: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Additional Criteria	100 words. Nothing required	100 words. Nothing required	100 words.	100 words.

18.5.2 Advanced Primary Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered,

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accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

18.5.2.1 Applicant must report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2026 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of enrollees who either selected or were matched with a primary care clinician reported in the Certification Application for 2026 and 2027. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

18.5.2.2 Applicant must report all payment methods used for primary care services and number of providers paid under each category in 2026 in Attachment J_QHP-IND_Run Charts as outlined by the Office of Health Care Affordability (OHCA). If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2026 and 2027, including the payment strategies for the top five (5) physician groups. Report data by product (HMO, PPO, EPO, Other). References: HCP LAN Alternative Payment Model APM Framework: <https://hcai.ca.gov/wp-content/uploads/2026/06/THCE-Data-Submission-Guide-v3.0.pdf>

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

18.5.3 Comprehensive Pregnancy and Postpartum Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to pregnancy and postpartum health.

Applicant must:

- 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section).
- 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals work toward reducing pregnancy and postpartum health disparities in alignment with Department of Health Care Services (DHCS).

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3) Consider a hospital's NTSV C-section rate, improvement trajectory, and engagement in quality improvement efforts, such as participation in coaching when making maternity hospital contracting decisions. Covered California recognizes that no single measure should determine network participation; however, sustained poor performance without demonstrated improvement must be addressed through contracting terms and corrective actions.

New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for NTSV C-sections compared to vaginal deliveries. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote maternal and newborn health and reduce low-value care.

Returning Applicants contracted with Covered California for more than one (1) year must report on these payment methodologies in their Certification Application, including the percentage of network hospitals and physicians paid under value-based models that minimize incentives for unnecessary surgical delivery.

Returning Applicants, contracted with Covered California for two (2) or more years, must also demonstrate measurable progress in expanding and strengthening these methodologies across their network.

4) Strategize contracting efforts to stabilize the pregnancy and postpartum workforce by expanding the network to include more midwives and doulas, ensuring patients have the autonomy to share their treatment preferences and goals, actively participating in shared decision-making processes with their care team.

18.5.3.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's pregnancy and postpartum payment requirements, supporting medically necessary, high-value care and reducing low-value care, and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered California for two (2) or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select "Not applicable."

Single, Pull-down list.

- 1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements,
- 2: Not confirmed,
- 3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

18.5.3.2 Applicant must report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2026 in Attachment J_QHP-IND_Run Charts. A list of all California hospitals participating in the MDC can be found here: <https://www.cmqcc.org/about-cmqcc/member-hospitals>. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2024, 2025, 2026 and 2027, if applicable.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

18.5.3.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must adopt and expand value-based payment strategies structured to support medically necessary, high-value care that promotes health, resilience, and disease prevention for the pregnancy

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and postpartum patient and their family with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2026 or in the first year of QHP certification if after 2026. These value-based payment strategies include: 1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Applicant must report various reimbursement models for deliveries and number of network hospitals and physicians paid using each payment strategy in 2026 in Attachment J - QHPIND Run Charts. Describe all existing payment models for Pregnant and Postpartum delivery procedures. Specifically, explain how the system for paying providers is structured so that there is no financial incentive for NTSV cesarean sections compared to vaginal births.

Applicants must enter the percentages reported in the Certification Applications for 2024, 2025, 2026 and 2027, if applicable.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, new entrant Applicant

18.5.3.4 Currently contracted Applicant of two (2) or more years must complete Attachment K1_QHP-IND-CCSB_QIS 1 Work Plan - Comprehensive Pregnancy and Postpartum Care to describe strategies for the delivery of high value care and report any progress made since the last QIS submission. Each question in this application is designed to assess distinct aspects of the Applicant's strategy, performance, and commitment to continuous improvement.

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on cross-references (e.g., "see previous response") or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select "Not applicable."

Address each of the following in the work plan narrative:

- Description of how Hospital Safety Ratings are communicated to enrollees to promote autonomy in decision making.
- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.6% or less.
- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2026.
- Description of the expansion strategy for in-network Doulas and Midwife providers.
- Description of how access to culturally and linguistically appropriate pregnancy and postpartum care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services are communicated and promoted to enrollees.
- Description of how Applicant promotes and encourages all in-network hospitals that provide pregnancy and postpartum health services to use the resources provided by CMQCC and enroll in the CMQCC MDC.

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- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement.
- Description of how local social support services such as food, housing, and transportation programs and other resources are available to members in need of additional support in the postpartum period.
- Further implementation plans for 2027 including milestones and targets for 2028 and 2029.
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

Note: Refer to Appendix M for hospital C-section rates.

Single, Radio group.

1: Attached,

2: Not attached,

3: Not applicable, currently contracted Applicant with fewer than two (2) years or new entrant Applicant

18.5.4 Hospital Quality, Value, and Patient Safety

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer collaborative approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce wasteful healthcare spending.

Applicant must work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients and contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of enrollees. Applicant will improve quality and cost performance across its contracted hospitals and track and report progress and strategies.

New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for low-value or avoidable services, including hospital-acquired infections (HAIs), readmissions, or other preventable complications. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote patient safety, improve clinical outcomes, and reduce wasteful spending.

Returning Applicants contracted with Covered California for more than one (1) year must report on hospital payment methodologies in their Certification Application, including the percentage of network hospitals reimbursed under models that tie payment to quality, value, and patient safety (e.g., HAIs, readmissions, patient satisfaction).

Returning Applicants contracted with Covered California for two (2) or more years, must also demonstrate measurable progress in expanding and strengthening value-based hospital payment strategies across their network and show collaboration efforts with other QHP issuers to improve hospital safety and reduce hospital-acquired infections.

18.5.4.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's Hospital Quality, Value and Safety requirements, supporting medically necessary, high-value care and reducing low-value care,

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and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered California for two (2) or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select “Not applicable.”

Single, Pull-down list.

- 1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements,
- 2: Not confirmed,
- 3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

18.5.4.2 Applicant must report progress on the adoption of hospital payment methodologies for each general acute care hospital in its networks that ties payment to quality value, and safety. Report, across all lines of business, excluding Medicare, the percentage of hospital reimbursements tied to quality, value and safety and the metrics applied for performance-based payments in Attachment J - QHP-IND Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. “Quality performance” includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, new entrant Applicant

18.5.4.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must report the number and percent of hospitals contracted under the model described in question 18.5.4.2 with reimbursement at risk for quality performance in 2026 in Attachment J_QHP-IND_Run Charts.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not Applicable, new entrant Applicant

18.5.4.4 Currently contracted Applicant of (2) or more years must complete Attachment K2_QHP-IND-CCSB_QIS 2 Work Plan-Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs
- How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality
- Further implementation plans for 2027 including milestones and targets for 2028 and 2029
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on

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cross-references (e.g., “see previous response”) or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select “Not applicable.”

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available resources available to hospitals: CMS Quality Improvement Organization (QIO) Program:

<https://www.cms.gov/medicare/quality/quality-improvement-organizations>

Health Services Advisory Group (HSAG) Quality Improvement and Innovation for Region 7:

<https://www.hsaq.com/en/medicare-providers/hospitals/>

Hospital HAI rates can be reviewed individually at: <http://calhospitalcompare.org/>

Single, Radio group.

1: Attached,

2: Not attached,

3: Not applicable, Applicant contracted for fewer than two (2) years with Covered California

18.6 Cost Containment

18.6.1 Cost Containment for Statewide Spending

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California collaborates closely with the California Department of Health Care Access and Information (HCAI) and the Office of Health Care Affordability (OHCA) to ensure the public interest is served by enabling all Californians to access health care that is not only accessible and affordable but also equitable, of high quality, and universally available. In its role as the state-based marketplace, Covered California actively monitors the advancement toward reduced overall healthcare expenditures across the state and manages strategies for cost containment. In this section, Applicants will be assessed on the degree to which cost growth targets have been incorporated into pricing models and contracting strategies.

18.6.1.1 Applicant must describe strategies in place for cost containment based on OHCA's Health Care Spending Target. For each targeted service category (e.g., facility inpatient, facility outpatient, professional inpatient, professional outpatient, Mental Health and Substance Abuse (MHSA), lab, radiology, specialty pharmacy, prescription drug):

- Name and describe the service category or categories being targeted.
- Provide the specific strategy or strategies used (e.g., network curation, value-based contracting, site-of-care optimization, utilization management, price negotiation, etc.).
- Specify applicable lines of business, noting any differences (e.g., Covered California Individual Market, CCSB, off-Exchange).
- Briefly note progress to date, future targets, how quality is integrated and access preserved, quantifiable metrics (e.g., % reductions, cost trends, quality outcomes), and any key challenges with mitigation approaches.

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- Highlight how these strategies reduce costs for members by enabling other levers, such as premium reduction.

200 words.

18.6.1.2 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. Covered California is interested in learning about the Applicant's analysis regarding its own costs, such as identifying the root cause(s) of increasing costs in these areas. For each of these 3 cost drivers, identify and describe the root cause(s) of increasing costs, if identified by Applicant. If Applicant has not identified the root cause(s) of increasing costs in these areas, indicate this below.

Multi, Checkboxes.

1: Identify and describe the root cause(s) for high cost for specialty pharmacy: [200 words].

2: Identify and describe the root cause(s) for high cost for ER visits: [200 words].

3: Identify and describe the root cause(s) for high cost for ambulance: [200 words].

18.6.1.3 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. For each of these 3 cost drivers, describe any strategies Applicant has implemented to contain cost.

Multi, Checkboxes.

1: Describe cost containment strategies for specialty pharmacy: [200 words].

2: Describe cost containment strategies for ER visits: [200 words].

3: Describe cost containment strategies for ambulance: [200 words].

18.6.1.4 Applicant must describe strategies it has implemented to reduce premiums for members.

200 words.

18.6.2 Cost Containment for Formulary Pricing

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California is concerned with the trend in rising prescription drug costs, as pharmacy trend has outpaced medical trend for several years. These rising prescription drug costs include specialty pharmacy, and compounding increases in costs of generic drugs, which are a growing driver of total cost of care. In this section, Applicants will be assessed on the extent to which value, including cost, access, and clinical outcomes, is considered in the construction of formularies, Pharmacy Benefit Management (PBM) relationships, and delivery of pharmacy services.

18.6.2.1 Applicant must describe strategies to improve member affordability of pharmaceuticals. In the response, include the structure of pharmacy network partners, use of product and service carve-outs, and the application drug price benchmarking tools (e.g., ICER and NADAC). Specify whether and how rebates, spread pricing and comprehensive audit rights are leveraged through fair and competitive contracting practices. Highlight how these strategies reduce costs for members and support long-term value in the pharmacy benefit.

200 words.

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18.6.2.2 Applicant must describe how it incorporates value (maximizing outcomes achieved per dollar spent) and cost-effectiveness (relative value of different treatments) in its formulary design. Specify the data sources, evaluation methods (e.g., comparative effectiveness, health outcomes data), and clinical or financial criteria used to inform decisions. If applicable, describe any resulting impacts on formulary structure, tiering, or member affordability. Responses must be specific and demonstrate how value and cost-effectiveness considerations influence actual formulary decisions.

200 words.

18.6.2.3 Applicant must describe strategy for managing specialty pharmacy and biologic therapies, including Glucagon-like peptide-1 (GLP-1) receptor agonists. Include how the strategy supports clinical appropriateness, member affordability, and cost-effective utilization. Describe any use of utilization management tools (e.g., prior authorization, step therapy, site-of-care optimization), network design, or contracting arrangements. Where applicable, highlight how these approaches have impacted access, member experience, health outcomes, or total cost of care.

200 words.

18.6.2.4 Does Applicant promote and use biosimilar drugs? If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

18.6.2.5 Does Applicant provide decision support for prescribers and enrollees in selecting appropriate, efficacious, high-value treatments and more cost-effective alternatives when applicable? If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

19 Exclusive Provider Organization (EPO)

19.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

19.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.

Single, Radio group.

1: Confirmed,

2: Not confirmed, [200 words]

19.1.2 Applicant must confirm it will comply with the contractual requirement to file an off-exchange plan that includes the benefits and services at the cost-sharing and actuarial cost level described in

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the Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design. This plan must not have any rate increase or cost attributable to the cost of the cost-sharing reduction program. This plan must be filed with the Applicant's applicable regulator for approval.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

19.1.3 Applicant must confirm all guidelines and due dates will be followed, as listed in Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028.

Single, Pull-down list.

1: Confirmed,

2: Not confirmed

19.1.4 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND_Patient-Centered Benefit Plan Design Deviations with all requested deviations, including regulator required deviations. If Applicant is currently contracted, Applicant must include previously approved deviations that Applicant requests to offer again. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval.

Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Single, Pull-down list.

1: Yes, deviations requested, attached.,

2: No, no deviations requested

19.1.5 Covered California encourages Applicant to offer plan products which include all ten (10) Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the coverage year Patient-Centered Benefit Plan Design which includes all ten (10) Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.

Single, Radio group.

1: Yes. Individual market QHPs proposed for coverage year include all ten (10) Essential Health Benefits, explain [50 words] .,

2: No. Individual market QHPs proposed for coverage year does not include all ten (10) Essential Health Benefits, explain [50 words] .

19.1.6 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees, such as the Evidence of Coverage or Policy document.

Single, Radio group.

1: Yes, describe: [100 words] ,

2: No, describe: [100 words]

19.1.7 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the

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requirements in Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028. Applicant must comply with state and federal laws.

Single, Radio group.

1: Confirmed,

2: Not confirmed:

19.2 Benefit Administration

Questions 19.2.17-19.2.18 and 19.2.25-19.2.27 are required for currently contracted Applicants. All questions are required for new Applicants. All questions should be answered at the product level, not at the Issuer level.

19.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit: Activities conducted for consumer education and communication. Oversight conducted for dental quality and network management. If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

1: Offer benefit directly under full-service license: [100 words] ,

2: Subcontractor relationship: [100 words] ,

3: Not Applicable

19.2.2 Applicant must describe how it administers child eye care benefits. Use the details section to specifically address the following:

- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the child eye care benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

1: Offer benefit directly under full-service license: [200 words] ,

2: Subcontractor relationship: [200 words] ,

3: Other: [200 words]

19.2.3 Applicant must indicate how it administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.

Single, Radio group.

1: Applicant offers benefit directly under full-service license,

2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words] ,

3: Other, describe: [50 words]

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19.2.4 Applicant must describe activities it conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.
200 words.

19.2.5 Applicant must specify how it monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	Monitoring Completed by Applicant or Subcontractor
Provider Network Development	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Network Adequacy	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Appointment Wait Times	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Clinical Quality Performance	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Patient Experience	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Cultural and Linguistic Concordance	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Referral Process between Physical Health and Behavioral Health Providers	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Care Coordination	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Virtual Care	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both

19.2.6 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

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19.2.7 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

19.2.8 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

19.2.9 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

19.2.10 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

19.2.11 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

19.2.12 Applicant must describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

19.2.13 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.

Single, Radio group.

1: NCQA Accredited,

2: Not NCQA Accredited, [100 words]

19.2.14 Applicant must describe the oversight and accountability process for and any performance incentives associated with behavioral health virtual care.

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Single, Radio group.

- 1: NCQA Accredited,
- 2: Not NCQA Accredited, [100 words]

19.2.15 Applicant must describe all virtual care point solutions and list vendors used. Report NCQA Virtual Accreditation (Primary Care and Urgent Care) status for all vendors as applicable.

200 words.

19.2.16 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Applicant must describe its ability to support virtual care consultations, either through a contractor or provided by the medical group or provider.

Multi, Checkboxes.

- 1: Plan does not offer or allow virtual care consultations,
- 2: Virtual care with interactive face to face dialogue (video and audio),
- 3: Virtual care with interactive dialogue over the phone,
- 4: Virtual care asynchronous store and forward,
- 5: Virtual care mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other,
- 6: Remote patient monitoring,
- 7: e-Consult: provider-to-provider,
- 8: Other (specify): [20 words]

19.2.17 Do cost shares for virtual care services differ from the standard benefit design for that product?

Single, Radio group.

- 1: No, (no attachment),
- 2: Yes, Attachment D required

19.2.18 Applicant must confirm if it reimburses providers for virtual care consultations conducted.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

19.2.19 Applicant must describe the availability of web or virtual care consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for virtual care. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English.

200 words.

19.2.20 Applicant must describe how Applicant promotes virtual care (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

19.2.21 Specific to behavioral health providers, Applicant must describe how it promotes integration and coordination of care between in-person providers and virtual care providers.

200 words.

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19.2.22 Covered California requires contracted QHP Issuers to offer virtual care for behavioral health services. In the following table, Applicant must indicate whether it offers virtual care for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its telehealth capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Virtual Care Offered	Education Efforts	Details
Applicant offers virtual care for behavioral health services	Multi, Checkboxes. 1: Virtual care for emergency behavioral health offered, 2: Virtual care for outpatient behavioral health (not integrated) offered, 3: Virtual care for inpatient behavioral health offered, 4: Virtual care for integrated primary care and behavioral health offered, 5: Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe, 6: Other, describe, 7: No, Applicant does not offer virtual care for behavioral health services	Multi, Checkboxes. 1: Member welcome packets, 2: Educational emails, 3: Educational mailings, 4: Website notices or information, 5: Member portal notices or information, 6: Information available through provider directory, 7: Member app notices or information, 8: Information available through call center, 9: Other, describe	200 words.

19.2.23 Does Applicant use a behavioral health virtual care vendor?

Single, Radio group.

1: Yes, specify vendor: [20 words] ,

2: No

19.2.24 Applicant must describe the referral process for members who are in need of higher levels of behavioral health care (who initiates it, how, etc.) and the support offered. State the access timeline with specific timelines and address both urgent and non-urgent pathways and out-of-network contingencies for members who need higher care levels.

200 words.

19.2.25 Based on the definition of Generative Artificial Intelligence (GenAI) as defined in Section 21 - Glossary, Applicant must describe how it uses Generative Artificial Intelligence (GenAI) to support enrollees.

100 words.

19.2.26 Applicant must report all clinical use cases in which GenAI is used.

200 words.

19.2.27 Applicant must describe their GenAI governance approach.

100 words.

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19.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

19.3.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the necessary information to allow cross-network comparisons and evaluations. Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new, or if it already exists in Covered California, and it must include the network name.

Single, Radio group.

- 1: Attached, Applicant attesting to new network (confirming provider data is for the certification year), [10 words] ,
- 2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words] ,
- 3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year, [10 words] ,
- 4: Not attached, explain [50 words]

19.3.2 Applicant must complete all tabs in Attachment E3 - EPO Provider Network Tables, for their EPO Network.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

19.3.3 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name the leasing organization, and state whether or not it has the ability to influence provider contract terms.

Single, Radio group.

- 1: Applicant contracts and manages network,
- 2: Applicant leases network, describe [500 words]

19.3.4 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The implementing regulations would include regulations relating to consumer access to primary, specialty, behavioral health and hospital care based on enrollee access.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

19.3.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

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Single, Radio group.

- 1: Confirmed,
- 2: Not Confirmed

19.3.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following:

The collection of race/ethnicity information of the population and providers	100 words.
The collection and publication of practitioner language information	100 words.
The tools or services used to meet the language needs of the population;	100 words.
Provider participation in cultural humility training	100 words.

19.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not Confirmed

19.3.8 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

Does Applicant offer coverage in a California county or region bordering another state?	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California Enrollees? If yes, explain in detail how this coverage is offered. If not, explain why the coverage is not offered.	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, [200 words] 3: Not Applicable

19.3.9 Applicant must describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California's attention.

100 words.

19.4 Essential Community Provider (ECP)

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant must provide reasonable and timely access for Low-income and Medically Underserved populations in each geographic rating region where Applicant's QHP proposals will provide services, by providing access to Essential Community Providers (ECPs) under criteria specified in this section.

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Applicants with an integrated delivery structure, as determined by Covered California using criteria in question 19.4.3, may qualify for assessment under an alternative standard.

For the purposes of this Section the following definitions shall apply:

- “Low-income” populations are individuals and families living at or below 200% of Federal Poverty Level.
- “Medically Underserved” populations are defined as:
 1. Individuals with HIV/AIDS,
 2. American Indians and Alaska Natives,
 3. Individuals living in Maternity Care Target Areas, as published by the Health Resources and Services Administration (HRSA),
 4. Individuals living in designated Health Professional Shortage Areas, as published by HRSA,
 5. Individuals living in designated Medically Underserved Areas, as published by HRSA, and
 6. Individuals belonging to designated Medically Underserved Populations, as published by HRSA.
- Essential Community Providers include providers in the following categories:
 1. Entities that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B (“340B Entities”).
 2. Entities that participate in the program described in Public Health Service Act § 1927(c)(1)(D)(i)(IV).
 3. Entities that participate in California’s Disproportionate Share Hospital (DSH) Program, per the final DSH Eligibility List for the current fiscal year.
 4. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.
 5. Federally Qualified Health Centers.
 6. Community Clinics or health centers either licensed as a “community clinic” or “free clinic”, by the State under Health and Safety Code section 1204, subdivision (a), or exempt from licensure under Health and Safety Code section 1206.
 7. State-owned family planning service sites or governmental family planning sites not receiving Federal funding under special programs, including Title X of the PHS Act, unless they have lost their status under that section, or sections 340(B) or 1927 of the PHS Act due to violations of Federal law.
 8. Pediatric oral services providers.
 9. Recipients of the Department of Health Care Access and Information’s Community-Based Organization (CBO) Behavioral Health Workforce Grant Program.
 10. Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index.
 11. Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index.

Covered California’s published Consolidated Essential Community Provider List is available at: <http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/>.

19.4.1 Applicant must demonstrate that its QHP proposals meet requirements for provider sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant’s provider network data submission to assess Applicant’s ECP network. All the criteria below must be met.

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1. Applicant must demonstrate a mix of ECPs (hospital and non-hospital) reasonably distributed to serve Low-income and Medically Underserved populations; **AND**
2. Applicant must include at least one ECP hospital (including 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county, and children's hospitals) per each county, or, in counties with more than one geographic rating region, one ECP hospital in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
3. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal Primary care providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted primary care ECPs located in each geographic rating region. All primary care ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list.
4. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted behavioral health ECPs located in each geographic rating region. All behavioral health ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list.
5. If Applicant is unable to achieve the sufficiency requirements in question 19.4.1 criteria 3 and 4, Applicant must demonstrate contracts with at least fifteen percent (15%) of 340B non-hospital providers in each applicable geographic rating area where Contractor's QHPs provide Covered Services to Covered California Enrollees, and provide documentation of good faith efforts Contractor is taking or will take to achieve the sufficiency requirements in question 19.4.1 criteria 3 and 4. Covered California will calculate the percentage of contracted 340B entities located in each geographic rating region. All 340B entity service sites shall be counted in the denominator, in accordance with the PY2025_QHP-QDP-IND-CCSB_consolidated ECP list-Final version of Covered California's Consolidated ECP list.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved provider sufficiency and a balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of Low-income and Medically Underserved populations throughout the county that are not served by a single contracted ECP hospital.

Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

19.4.2 Applicant must demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant's provider network data submission to assess Applicant's ECP network. All the criteria below must be met.

1. Applicant must demonstrate the nature, type, and distribution of ECP contracting arrangements in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**

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2. Applicant must demonstrate a balance of hospital and non-hospital ECPs in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
3. Applicant must demonstrate the extent to which providers are accessible to and provide services that meet the needs of Low-income and Medically Underserved populations.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved a sufficient geographic distribution and balance between hospital and non-hospital requirements.

Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

19.4.3 Alternate standard. If Applicant provides a majority of covered professional services through providers employed by the Applicant or through a single contracted medical group, it may request to be evaluated under the alternate standard. The alternate standard requires the Applicant to provide services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories listed above and demonstrate that it does so in each geographic rating region where the QHP provides services to Covered California Enrollees, either through its own integrated delivery system or by offering a contract to at least one ECP outside of its system in each such category.

Applicant requesting consideration under the alternate standard must demonstrate eligibility through one of the following:

1. Employed Providers
 - a. Majority of covered services are rendered by providers employed by Applicant **AND**
 - b. Majority of Applicant's contracts with participating providers are at risk under capitation
2. Single Contracted Medical Group
 - a. Majority of covered services are rendered by a single contracted medical group **AND**
 - b. Majority of Applicant's provider services are at risk under capitation

Applicant requesting consideration under the alternate standard must submit a written description showing the following:

1. How Applicant's network is designed to ensure reasonable and timely access for Low-income, and Medically Underserved individuals (e.g., 24/7 telephone access); **AND**
2. Tracking quantitative data or efforts Applicant will undertake to measure how Low-income and Medically Underserved individuals are accessing needed health care services (e.g., maps of low-income members relative to 30-minute drive time to providers; survey of low-income members experience such as Consumer Assessment of Healthcare Providers Systems (CAHPS) "Getting Needed Care" survey).

Applicant must produce access maps to demonstrate the extent to which it provides services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories. If existing provider capacity does not meet the above criteria, Applicant may be required to provide additional contracted or out-of-network care. Applicants are encouraged to consider contracting with identified ECPs to provide reasonable and timely access for Low-income, Medically Underserved communities.

Applicant must confirm whether it is requesting evaluation under the alternative ECP standard.

Single, Pull-down list.

- 1: Confirmed, requesting consideration of alternate standard, explanation, including explanation of alternate standard

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eligibility, and access maps attached,
2: Not requesting consideration under the alternate standard.

19.5 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Comprehensive Pregnancy and Postpartum Care
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2027 but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

19.5.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

19.5.1.1 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

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	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Hospital Quality	Multi, Checkboxes. 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data, 4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Hospital Cost	Multi, Checkboxes. 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Additional Criteria	100 words.	100 words.	100 words.	100 words.

19.5.1.2 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Provider Quality	Multi, Checkboxes. 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.

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Provider Cost	<i>Multi, Checkboxes.</i> 1: Total Cost of Care data, 2: Comparison to other physician or physician groups in geographic area, 3: Other, explain	<i>Multi, Checkboxes.</i> 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Additional Criteria	100 words. Nothing required	100 words. Nothing required	100 words.	100 words.

19.5.2 Advanced Primary Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

19.5.2.1 Applicant must report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2026 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of enrollees who either selected or were matched with a primary care clinician reported in the Certification Application for 2026 and 2027. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

19.5.2.2 Applicant must report all payment methods used for primary care services and number of providers paid under each category in 2026 in Attachment J_QHP-IND_Run Charts as outlined by the Office of Health Care Affordability (OHCA). If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2026 and 2027, including the payment strategies for the top five (5) physician groups. Report data by product (HMO, PPO, EPO, Other). References: HCP LAN Alternative Payment Model APM Framework: <https://hcai.ca.gov/wp-content/uploads/2026/06/THCE-Data-Submission-Guide-v3.0.pdf>

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Single, Pull-down list.

- 1: Attached,
- 2: Not attached

19.5.3 Comprehensive Pregnancy and Postpartum Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to pregnancy and postpartum health.

Applicant must:

- 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section).
- 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals work toward reducing pregnancy and postpartum health disparities in alignment with DHCS.
- 3) Consider a hospital's NTSV C-section rate, improvement trajectory, and engagement in quality improvement efforts, such as participation in coaching when making maternity hospital contracting decisions. Covered California recognizes that no single measure should determine network participation; however, sustained poor performance without demonstrated improvement must be addressed through contracting terms and corrective actions.

New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for NTSV C-sections compared to vaginal deliveries. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote maternal and newborn health and reduce low-value care.

Returning Applicants contracted with Covered California for more than one (1) year must report on these payment methodologies in their Certification Application, including the percentage of network hospitals and physicians paid under value-based models that minimize incentives for unnecessary surgical delivery.

Returning Applicants, contracted with Covered California for two (2) or more years must also demonstrate measurable progress in expanding and strengthening these methodologies across their network.

- 4) Strategize contracting efforts to stabilize the pregnancy and postpartum workforce by expanding the network to include more midwives and doulas, ensuring patients have the autonomy to share their treatment preferences and goals, actively participating in shared decision-making processes with their care team.

19.5.3.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's pregnancy and postpartum payment requirements, supporting medically necessary, high-value care and reducing low-value care, and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered

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California for two (2) or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select “Not applicable.”

Single, Pull-down list.

1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements,

2: Not confirmed,

3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

19.5.3.2 Applicant must report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2026 in Attachment J_QHP-IND_Run Charts. A list of all California hospitals participating in the MDC can be found here: <https://www.cmqcc.org/about-cmqcc/member-hospitals>. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2024, 2025, 2026 and 2027, if applicable.

Single, Pull-down list.

1: Attached,

2: Not attached

19.5.3.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must adopt and expand value-based payment strategies structured to support medically necessary, high-value care that promotes health, resilience, and disease prevention for the pregnancy and postpartum patient and their family with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2026 or in the first year of QHP certification if after 2026. These value-based payment strategies include: 1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Applicant must report various reimbursement models for deliveries and number of network hospitals and physicians paid using each payment strategy in 2026 in Attachment J_QHP-IND Run Charts. Describe all existing payment models for Pregnant and Postpartum delivery procedures. Specifically, explain how the system for paying providers is structured so that there is no financial incentive for NTSV cesarean sections compared to vaginal births.

Applicants enter the percentages reported in the Certification Applications for 2024, 2025, 2026 and 2027, if applicable.

Single, Pull-down list.

1: Attached,

2: Not attached,

3: Not applicable, new entrant Applicant

19.5.3.4 Currently contracted Applicant of two (2) or more years must complete Attachment K1_QHP-IND-CCSB_QIS 1 Work Plan - Comprehensive Pregnancy and Postpartum Care to describe strategies for the delivery of high value care and report any progress made since the last QIS submission. Each question in this application is designed to assess distinct aspects of the Applicant's strategy, performance, and commitment to continuous improvement.

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on cross-references (e.g., “see previous response”) or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider

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participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select “Not applicable.”

Address each of the following in the work plan narrative:

- Description of how Hospital Safety Ratings are communicated to enrollees to promote autonomy in decision making.
- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.6% or less
- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2026.
- Description of the expansion strategy for in-network Doula and Midwife providers.
- Description of how access to culturally and linguistically appropriate pregnancy and postpartum care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services are communicated and promoted to enrollees.
- Description of how Applicant promotes and encourages all in-network hospitals that provide pregnancy and postpartum health services to use the resources provided by CMQCC and enroll in the CMQCC MDC
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement
- Description of how local social support services such as food, housing, and transportation programs and other resources are available to members in need of additional support in the postpartum period.
- Further implementation plans for 2027 including milestones and targets for 2028 and 2029
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

Note: Refer to Appendix M for hospital C-section rates.

Single, Radio group.

1: Attached,

2: Not attached,

3: Not applicable, currently contracted Applicant with fewer than two (2) years or new entrant Applicant

19.5.4 Hospital Quality, Value, and Patient Safety

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer collaborative approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce wasteful healthcare spending.

Applicant must work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients and contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of enrollees. Applicant will improve quality and cost performance across its contracted hospitals and track and report progress and strategies.

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New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for low-value or avoidable services, including hospital-acquired infections (HAIs), readmissions, or other preventable complications. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote patient safety, improve clinical outcomes, and reduce wasteful spending.

Returning Applicants contracted with Covered California for more than one (1) year must report on hospital payment methodologies in their Certification Application, including the percentage of network hospitals reimbursed under models that tie payment to quality, value, and patient safety (e.g., HAIs, readmissions, patient satisfaction).

Returning Applicants contracted with Covered California for two (2) or more years, must also demonstrate measurable progress in expanding and strengthening value-based hospital payment strategies across their network and show collaboration efforts with other QHP issuers to improve hospital safety and reduce hospital-acquired infections.

19.5.4.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's Hospital Quality, Value and Safety requirements, supporting medically necessary, high-value care and reducing low-value care, and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered California for two (2) or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select "Not applicable."

Single, Pull-down list.

- 1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements,
- 2: Not confirmed,
- 3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

19.5.4.2 Applicants must report the progress on the adoption hospital payment methodologies for each general acute care hospital in its networks that ties payment to quality value, and safety. Report, across all lines of business, excluding Medicare, the percentage of hospital reimbursements tied to quality, value and safety and the metrics applied for performance-based payments in Attachment J - QHP-IND Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. "Quality performance" includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, new entrant Applicant

19.5.4.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must report the number and percent of hospitals contracted under the model described in question 19.5.4.2 with reimbursement at risk for quality performance in 2026 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare.

Single, Pull-down list.

- 1: Attached,

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2: Not attached,
3: Not Applicable, new entrant Applicant

19.5.4.4 Currently contracted Applicant of (2) or more years must complete Attachment K2_QHP-IND-CCSB_QIS 2 Work Plan-Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative:

- How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs
- How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines
- How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals
- Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality
- Further implementation plans for 2027 including milestones and targets for 2028 and 2029
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on cross-references (e.g., “see previous response”) or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select “Not applicable.”

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available resources available to hospitals: CMS Quality Improvement Organization (QIO) Program: <https://www.cms.gov/medicare/quality/quality-improvement-organizations>

Health Services Advisory Group (HSAG) Quality Improvement and Innovation for Region 7: <https://www.hsag.com/en/medicare-providers/hospitals/>

Hospital HAI rates can be reviewed individually at: <http://calhospitalcompare.org/>

Single, Radio group.

1: Attached,
2: Not attached,
3: Not applicable, Applicant contracted for fewer than two (2) years with Covered California

19.6 Cost Containment

19.6.1 Cost Containment for Statewide Spending

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

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Covered California collaborates closely with the California Department of Health Care Access and Information (HCAI) and the Office of Health Care Affordability (OHCA) to ensure the public interest is served by enabling all Californians to access health care that is not only accessible and affordable but also equitable, of high quality, and universally available. In its role as the state-based marketplace, Covered California actively monitors the advancement toward reduced overall healthcare expenditures across the state and manages strategies for cost containment. In this section, Applicants will be assessed on the degree to which cost growth targets have been incorporated into pricing models and contracting strategies.

19.6.1.1 Applicant must describe strategies in place for cost containment based on OHCA's Health Care Spending Target. For each targeted service category (e.g., facility inpatient, facility outpatient, professional inpatient, professional outpatient, Mental Health and Substance Abuse (MHSA), lab, radiology, specialty pharmacy, prescription drug):

- Name and describe the service category or categories being targeted.
- Provide the specific strategy or strategies used (e.g., network curation, value-based contracting, site-of-care optimization, utilization management, price negotiation, etc.).
- Specify applicable lines of business, noting any differences (e.g., Covered California Individual Market, CCSB, off-Exchange).
- Briefly note progress to date, future targets, how quality is integrated and access preserved, quantifiable metrics (e.g., % reductions, cost trends, quality outcomes), and any key challenges with mitigation approaches.
- Highlight how these strategies reduce costs for members by enabling other levers, such as premium reduction.

200 words.

19.6.1.2 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. Covered California is interested in learning about the Applicant's analysis regarding its own costs, such as identifying the root cause(s) of increasing costs in these areas. For each of these 3 cost drivers, identify and describe the root cause(s) of increasing costs, if identified by Applicant. If Applicant has not identified the root cause(s) of increasing costs in these areas, indicate this below.

Multi, Checkboxes.

1: Identify and describe the root cause(s) for high cost for specialty pharmacy: [200 words].

2: Identify and describe the root cause(s) for high cost for ER visits: [200 words].

3: Identify and describe the root cause(s) for high cost for ambulance: [200 words].

19.6.1.3 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. For each of these 3 cost drivers, describe any strategies Applicant has implemented to contain cost.

Multi, Checkboxes.

1: Describe cost containment strategies for specialty pharmacy: [200 words].

2: Describe cost containment strategies for ER visits: [200 words].

3: Describe cost containment strategies for ambulance: [200 words].

19.6.1.4 Applicant must describe strategies it has implemented to reduce premiums for members.

200 words.

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19.6.2 Cost Containment for Formulary Pricing

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California is concerned with the trend in rising prescription drug costs, as pharmacy trend has outpaced medical trend for several years. These rising prescription drug costs include specialty pharmacy, and compounding increases in costs of generic drugs, which are a growing driver of total cost of care. In this section, Applicants will be assessed on the extent to which value, including cost, access, and clinical outcomes, is considered in the construction of formularies, Pharmacy Benefit Management (PBM) relationships, and delivery of pharmacy services.

19.6.2.1 Applicant must describe strategies to improve member affordability of pharmaceuticals. In the response, include the structure of pharmacy network partners, use of product and service carve-outs, and the application drug price benchmarking tools (e.g., ICER and NADAC). Specify whether and how rebates, spread pricing and comprehensive audit rights are leveraged through fair and competitive contracting practices. Highlight how these strategies reduce costs for members and support long-term value in the pharmacy benefit.

200 words.

19.6.2.2 Applicant must describe how it incorporates value (maximizing outcomes achieved per dollar spent) and cost-effectiveness (relative value of different treatments) in its formulary design. Specify the data sources, evaluation methods (e.g., comparative effectiveness, health outcomes data), and clinical or financial criteria used to inform decisions. If applicable, describe any resulting impacts on formulary structure, tiering, or member affordability. Responses must be specific and demonstrate how value and cost-effectiveness considerations influence actual formulary decisions.

200 words.

19.6.2.3 Applicant must describe strategy for managing specialty pharmacy and biologic therapies, including Glucagon-like peptide-1 (GLP-1) receptor agonists. Include how the strategy supports clinical appropriateness, member affordability, and cost-effective utilization. Describe any use of utilization management tools (e.g., prior authorization, step therapy, site-of-care optimization), network design, or contracting arrangements. Where applicable, highlight how these approaches have impacted access, member experience, health outcomes, or total cost of care.

200 words.

19.6.2.4 Does Applicant promote and use biosimilar drugs? If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

19.6.2.5 Does Applicant provide decision support for prescribers and enrollees in selecting appropriate, efficacious, high-value treatments and more cost-effective alternatives when applicable? If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

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Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

20 Other Network Type

20.1 Benefit Design

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

20.1.1 Applicant must confirm all products offered will comply with the coverage year Patient-Centered Benefit Plan Designs (PCBPD). If not, Applicant must explain why.

Single, Radio group.

1: Confirmed,

2: Not confirmed, [200 words]

20.1.2 Applicant must confirm it will comply with the contractual requirement to file an off-exchange plan that includes the benefits and services at the cost-sharing and actuarial cost level described in the Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design. This plan must not have any rate increase or cost attributable to the cost of the cost-sharing reduction program. This plan must be filed with the Applicant's applicable regulator for approval.

Single, Pull-down list.

1: Confirmed

2: Not confirmed

20.1.3 Applicant must confirm all guidelines and due dates will be followed, as listed in Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028.

Single, Pull-down list.

1: Confirmed,

2: Not confirmed

20.1.4 Applicant must indicate if it is requesting approval for any cost-sharing deviations from the coverage year Patient-Centered Benefit Plan Designs. If yes, Applicant must submit Attachment C_QHP-IND_Patient-Centered Benefit Plan Design Deviations with all requested deviations, including regulator required deviations. If Applicant is currently contracted, Applicant must include previously approved deviations that Applicant requests to offer again. In addition, Applicant must submit the same cost-sharing deviations to Applicant's applicable regulator for approval. Note: Alternate benefit design proposals are not permitted in the Individual Marketplace. Covered California's decision whether to approve or deny QHP specific proposed deviations are on a case-by-case basis and are not considered an alternate benefit design.

Single, Pull-down list.

1: Yes, deviations requested, attached.,

2: No, no deviations requested

20.1.5 Covered California encourages Applicant to offer plan products which include all ten (10) Essential Health Benefits, including the pediatric dental Essential Health Benefit. Applicant must indicate if it will adhere to the coverage year Patient-Centered Benefit Plan Design which includes all

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ten (10) Essential Health Benefits. Failure to offer a product without pediatric dental will not be grounds for rejection of Applicant's application.

Single, Radio group.

1: Yes. Individual market QHPs proposed for coverage year include all ten (10) Essential Health Benefits, explain [50 words] .

2: No. Individual market QHPs proposed for coverage year does not include all ten (10) Essential Health Benefits, explain [50 words] .

20.1.6 Applicant must indicate if proposed QHPs will include coverage of non-emergent out-of-network services. If yes, with respect to non-network, non-emergency claims, describe how non-emergent out-of-network coverage is communicated to enrollees in addition to the details provided in the Evidence of Coverage or Policy document. If no, describe how the lack of coverage for non-emergent out-of-network services coverage is communicated to enrollees, such as the Evidence of Coverage or Policy document.

Single, Radio group.

1: Yes, describe: [100 words] ,

2: No, describe: [100 words]

20.1.7 Applicant must confirm the coverage year Schedule of Benefits and Coverage (SBC), Evidence of Coverage (EOC) or Policy language describing proposed health Benefits will follow the requirements in Appendix D_QHP-IND_Submission Guidelines_Plan Year 2028. Applicant must comply with state and federal laws.

Single, Radio group.

1: Confirmed,

2: Not confirmed:

20.2 Benefit Administration

Questions 20.2.17-20.2.18 and 20.2.25-20.2.27 are required for currently contracted Applicants. All questions are required for new Applicants. All questions should be answered at the product level, not at the Issuer level.

20.2.1 If Applicant's proposed QHPs will include the pediatric dental essential health benefit, Applicant must describe how it intends to embed this benefit. In the description of the option selected, Applicant must describe how it will ensure that the provision of pediatric dental benefits adheres to contractual requirements, including pediatric dental quality measures. Specifically address the following for the pediatric dental Essential Health Benefit: Activities conducted for consumer education and communication. Oversight conducted for dental quality and network management. If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the pediatric dental benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

1: Offer benefit directly under full-service license: [100 words] ,

2: Subcontractor relationship: [100 words] ,

3: Not Applicable

20.2.2 Describe how Applicant administers child eye care benefits. Use the details section to specifically address the following:

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- Activities conducted for consumer education and communication related to child eye care benefits.
- Oversight conducted for quality and network management.

If the benefit is subcontracted, state the name of the contractor, and describe any performance incentives included in the child eye care benefits subcontractor contract including metrics used for performance assessment.

Single, Radio group.

- 1: Offer benefit directly under full-service license: [200 words] ,
2: Subcontractor relationship: [200 words] ,
3: Other: [200 words]

20.2.3 Indicate how Applicant administers mental health and substance use disorder (MHSUD) benefits as either administered directly by Applicant or subcontracted to a contractor.

Single, Radio group.

- 1: Applicant offers benefit directly under full-service license,
2: Applicant offers benefit through subcontractor, state the name of the contractor: [50 words] ,
3: Other, describe: [50 words]

20.2.4 Describe activities Applicant conducts to educate and communicate to consumers about mental health and substance use disorder (MHSUD) benefits and how to access MHSUD services.
200 words.

20.2.5 Specify how Applicant monitors the following components of network management, access, and quality of care for its mental health and substance use disorder (MHSUD) provider network, either directly by Applicant or by a subcontractor.

Network Management, Access, and Quality Monitoring Components	Monitoring Completed by Applicant or Subcontractor
Provider Network Development	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Network Adequacy	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Appointment Wait Times	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Clinical Quality Performance	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Patient Experience	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Cultural and Linguistic Concordance	<i>Single, Pull-down list.</i> 1: Applicant,

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	2: Subcontractor, 3: Both
Referral Process between Physical Health and Behavioral Health Providers	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Care Coordination	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both
Virtual Care	<i>Single, Pull-down list.</i> 1: Applicant, 2: Subcontractor, 3: Both

20.2.6 Describe the oversight and accountability process for and any performance incentives associated with behavioral health provider network development.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

20.2.7 Describe the oversight and accountability process for and any performance incentives associated with behavioral health network adequacy.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

20.2.8 Describe the oversight and accountability process for and any performance incentives associated with behavioral health appointment wait times.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

20.2.9 Describe the oversight and accountability process for and any performance incentives associated with behavioral health clinical quality.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

20.2.10 Describe the oversight and accountability process for and any performance incentives associated with behavioral health patient experience.

Single, Radio group.

- 1: NCQA Accredited,
2: Not NCQA Accredited, [100 words]

20.2.11 Describe the oversight and accountability process for and any performance incentives associated with behavioral health cultural and linguistic concordance.

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Single, Radio group.

- 1: NCQA Accredited,
- 2: Not NCQA Accredited, [100 words]

20.2.12 Describe the oversight and accountability process for and any performance incentives associated with the referral process between physical health and behavioral health Providers.

Single, Radio group.

- 1: NCQA Accredited,
- 2: Not NCQA Accredited, [100 words]

20.2.13 Describe the oversight and accountability process for and any performance incentives associated with behavioral health care coordination.

Single, Radio group.

- 1: NCQA Accredited,
- 2: Not NCQA Accredited, [100 words]

20.2.14 Describe the oversight and accountability process for and any performance incentives associated with behavioral health virtual care.

Single, Radio group.

- 1: NCQA Accredited,
- 2: Not NCQA Accredited, [100 words]

20.2.15 Describe all virtual care point solutions and list vendors used. Report NCQA Virtual Accreditation (Primary Care and Urgent Care) status for all vendors as applicable.

200 words.

20.2.16 Covered California supports the innovative use of technology to assist in higher quality, accessible, patient-centered care. Describe Applicant's ability to support virtual care consultations, either through a contractor or provided by the medical group or provider.

Multi, Checkboxes.

- 1: Plan does not offer or allow virtual care consultations,
- 2: Virtual care with interactive face to face dialogue (video and audio),
- 3: Virtual care with interactive dialogue over the phone,
- 4: Virtual care asynchronous store and forward,
- 5: Virtual care mobile health tools (reminders, alerts, monitoring) via text, instant messaging or other,
- 6: Remote patient monitoring,
- 7: e-Consult: provider-to-provider,
- 8: Other (specify): [20 words]

20.2.17 Do cost shares for virtual care services differ from the standard benefit design for that product?

Single, Radio group.

- 1: No, (no attachment),
- 2: Yes, Attachment D required

20.2.18 Applicant must confirm if it reimburses providers for virtual care consultations conducted.

Single, Radio group.

- 1: Confirmed,
- 2: Not confirmed

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20.2.19 Describe the availability of web or virtual care consultations in languages other than English. Include details on how members are notified about the availability of interpreter services for virtual care. Specify all languages offered in response and distinguish between use of interpreter service and availability of in-language consultations in languages other than English.

200 words.

20.2.20 Describe how Applicant promotes virtual care (either through vendor or medical group) as an alternative to the Emergency Department for urgent health issues (describe specific engagement efforts and any specific contractual requirements related to this topic for vendors or medical groups).

200 words.

20.2.21 Specific to behavioral health providers, describe how Applicant promotes integration and coordination of care between in-person providers and virtual care providers.

200 words.

20.2.22 Covered California requires contracted QHP Issuers to offer virtual care for behavioral health services. In the following table, indicate whether Applicant offers virtual care for behavioral health services by selecting which services are offered. Indicate how Applicant educates Covered California Enrollees on how to access services and how the information is displayed to Covered California Enrollees through Applicant's member portal and provider directory. If Applicant is not currently contracted with Covered California, provide a description of its virtual care capabilities, and indicate whether those services will be offered to Covered California Enrollees.

	Telehealth Offered	Education Efforts	Details
Applicant offers virtual care for behavioral health services	Multi, Checkboxes. 1: Virtual care for emergency behavioral health offered, 2: Virtual care for outpatient behavioral health (not integrated) offered, 3: Virtual care for inpatient behavioral health offered, 4: Virtual care for integrated primary care and behavioral health offered, 5: Remote monitoring (e.g., mobile health applications, self-management tools) offered, describe, 6: Other, describe, 7: No, Applicant does not offer virtual care for behavioral health services	Multi, Checkboxes. 1: Member welcome packets, 2: Educational emails, 3: Educational mailings, 4: Website notices or information, 5: Member portal notices or information, 6: Information available through provider directory, 7: Member app notices or information, 8: Information available through call center, 9: Other, describe	200 words.

20.2.23 Does Applicant use a behavioral health virtual care vendor?

Single, Radio group.

1: Yes, specify vendor: [20 words] ,

2: No

20.2.24 Applicant must describe the referral process for members who are in need of higher levels of behavioral health care (who initiates it, how, etc.) and the support offered. State the access timeline with specific timelines and address both urgent and non-urgent pathways and out-of-network contingencies for members who need higher care levels.

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200 words.

20.2.25 Based on the definition of Generative Artificial Intelligence (GenAI) as defined in Section 21 - Glossary, Applicant must describe how it uses Generative Artificial Intelligence (GenAI) to support enrollees.

100 words.

20.2.26 Applicant must report all clinical use cases in which GenAI is used.

200 words.

20.2.27 Applicant must describe their GenAI governance approach.

100 words.

20.3 Provider Network

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

20.3.1 Applicant must complete Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template for provider network data in the network submission that covers all geographic locations to which Applicant is applying for certification as a QHP. Attachment P_QHP-QDP-IND-CCSB_Provider Directory Data Template will follow the data file layout in the Covered California Provider Data Submission Guide with additional required telehealth information. The provider network submission for the certification year must be consistent with what will be filed to the appropriate regulator for approval if Applicant is selected as a QHP Issuer. Covered California requires the necessary information to allow cross-network comparisons and evaluations. Applicant must indicate if the network it intends to offer on Covered California in the Individual market for the certification year is new, or if it already exists in Covered California and include the network name.

Single, Radio group.

- 1: Attached, Applicant attesting to new network (confirming provider data is for the certification year), [10 words] ,
- 2: Attached, Applicant attesting to material changes to existing plan year Covered California network (confirming provider data is for the certification year), [10 words] ,
- 3: Attached, Applicant attesting to no material changes to existing plan year Covered California network for the certification year, [10 words] ,
- 4: Not attached, explain [50 words]

20.3.2 Applicant must complete all tabs in Attachment E4_QHP-IND_Other Provider Network Tables, for their Other Network.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

20.3.3 Does Applicant conduct provider negotiations and manage its own network or does Applicant lease a network from another organization? If Applicant leases a network, it must describe the length of the lease agreement, including start and end dates. It must also name the leasing organization, and state if the Applicant has the ability to influence provider contract terms.

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Single, Radio group.

- 1: Applicant contracts and manages network,
2: Applicant leases network, describe [500 words]

20.3.4 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 and any implementing regulations. The implementing regulations would include regulations relating to consumer access to primary care, specialty care, behavioral health care and hospital care, based on enrollee access.

Single, Pull-down list.

- 1: Confirmed,
2: Not Confirmed

20.3.5 Applicant must confirm it tracks ethnic and racial diversity in the population and ensures access to culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access.

Single, Radio group.

- 1: Confirmed,
2: Not Confirmed

20.3.6 Applicants must track ethnic and racial diversity in the population and ensure access to either culturally responsive or concordant providers, including relevant measurement criteria and benchmarks for ensuring adequate access. Applicant must describe in detail the following:

The collection of race/ethnicity information of the population and providers	100 words.
The collection and publication of practitioner language information	100 words.
The tools or services used to meet the language needs of the population;	100 words.
Provider participation in cultural humility training	100 words.

20.3.7 Applicant must confirm that it will respond to and adhere to the requirements of Health & Safety Code, § 1367.03 or Insurance Code, § 10133.54 for assessing enrollee wait times for appointments with primary, specialty, and behavioral health providers.

Single, Pull-down list.

- 1: Confirmed,
2: Not Confirmed

20.3.8 Many California residents live in counties bordering other states where the out-of-state services are closer than in-state services.

Does Applicant offer coverage in a California county or region bordering another state?	<i>Single, Pull-down list.</i> 1: Yes, 2: No, 3: Not Applicable
Does applicant allow out-of-state (non-emergency) providers to participate in networks to serve Covered California Enrollees? If yes, explain in detail how this coverage is offered. If not, explain why the coverage is not offered.	<i>Compound, Pull-down list.</i> 1: Yes: [200 words], 2: No, [200 words] 3: Not Applicable

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20.3.9 Describe any plans for network changes, by product, including any new medical groups or hospital systems that Applicant would like to highlight for Covered California's attention.

100 words.

20.4 Essential Community Provider (ECP)

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant must provide reasonable and timely access for Low-income and Medically Underserved populations in each geographic rating region where Applicant's QHP proposals will provide services, by providing access to Essential Community Providers (ECPs) under criteria specified in this section. Applicants with an integrated delivery structure, as determined by Covered California using criteria in question 20.4.3, may qualify for assessment under an alternative standard.

For the purposes of this Section the following definitions shall apply:

- "Low-income" populations are individuals and families living at or below 200% of Federal Poverty Level.
- "Medically Underserved" populations are defined as:
 1. Individuals with HIV/AIDS,
 2. American Indians and Alaska Natives,
 3. Individuals living in Maternity Care Target Areas, as published by the Health Resources and Services Administration (HRSA),
 4. Individuals living in designated Health Professional Shortage Areas, as published by HRSA,
 5. Individuals living in designated Medically Underserved Areas, as published by HRSA, and
 6. Individuals belonging to designated Medically Underserved Populations, as published by HRSA.
- Essential Community Providers include providers in the following categories:
 1. Entities that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B ("340B Entities").
 2. Entities that participate in the program described in Public Health Service Act § 1927(c)(1)(D)(i)(IV).
 3. Entities that participate in California's Disproportionate Share Hospital (DSH) Program, per the final DSH Eligibility List for the current fiscal year.
 4. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.
 5. Federally Qualified Health Centers.
 6. Community Clinics or health centers either licensed as a "community clinic" or "free clinic", by the State under Health and Safety Code section 1204, subdivision (a), or exempt from licensure under Health and Safety Code section 1206.
 7. State-owned family planning service sites or governmental family planning sites not receiving Federal funding under special programs, including Title X of the PHS Act,

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unless they have lost their status under that section, or sections 340(B) or 1927 of the PHS Act due to violations of Federal law.

8. Pediatric oral services providers.
9. Recipients of the Department of Health Care Access and Information's Community-Based Organization (CBO) Behavioral Health Workforce Grant Program.
10. Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index.
11. Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index.

Covered California's published Consolidated Essential Community Provider List is available at: <http://hbex.coveredca.com/stakeholders/plan-management/ecp-list/>.

20.4.1 Applicant must demonstrate that its QHP proposals meet requirements for provider sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant's provider network data submission to assess Applicant's ECP network. All the criteria below must be met.

1. Applicant must demonstrate a mix of ECPs (hospital and non-hospital) reasonably distributed to serve Low-income and Medically Underserved populations; **AND**
2. Applicant must include at least one ECP hospital (including 340B hospitals, Disproportionate Share Hospitals, critical access hospitals, academic medical centers, county, and children's hospitals) per each county, or, in counties with more than one geographic rating region, one ECP hospital in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. **AND**
3. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal Primary care providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted primary care ECPs located in each geographic rating region. All primary care ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list.
4. Applicant must demonstrate contracts with at least fifteen percent (15%) of Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees. Covered California will calculate the percentage of contracted behavioral health ECPs located in each geographic rating region. All behavioral health ECP service sites shall be counted in the denominator, in accordance with the most recent version of Covered California's Consolidated ECP list.
5. If Applicant is unable to achieve the sufficiency requirements in question 20.4.1 criteria 3 and 4, Applicant must demonstrate contracts with at least fifteen percent (15%) of 340B non-hospital providers in each applicable geographic rating area where Contractor's QHPs provide Covered Services to Covered California Enrollees, and provide documentation of good faith efforts Contractor is taking or will take to achieve the sufficiency requirements in question 20.4.1 criteria 3 and 4. Covered California will calculate the percentage of contracted 340B entities located in each geographic rating region. All 340B entity service sites shall be counted in the denominator, in accordance with the PY2025_QHP-QDP-IND-CCSB_consolidated ECP list-Final version of Covered California's Consolidated ECP list.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved provider sufficiency and a balance between hospital and non-hospital requirements. The above are the minimum requirements. For example, in populous counties, one ECP hospital will not suffice if there are concentrations of Low-income and Medically Underserved populations throughout the county that are not served by a single contracted ECP hospital.

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Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

20.4.2 Applicant must demonstrate that its QHP proposals meet requirements for geographic sufficiency of its Essential Community Provider (ECP) network. Covered California will use Applicant's provider network data submission to assess Applicant's ECP network. All the criteria below must be met. Applicant must demonstrate the nature, type, and distribution of ECP contracting arrangements in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. AND Applicant must demonstrate a balance of hospital and non-hospital ECPs in each geographic rating region where the QHP provides Covered Services to Covered California Enrollees. AND Applicant must demonstrate the extent to which providers are accessible to and provide services that meet the needs of Low-income and Medically Underserved populations.

Covered California will evaluate Applicant's provider network submission to determine if Applicant has achieved a sufficient geographic distribution and balance between hospital and non-hospital requirements.

Applicant must confirm that its provider network submissions include ECP designations. If Applicant is requesting the alternative standard due to its integrated delivery structure, it shall select not applicable.

Single, Pull-down list.

- 1: Confirmed,
- 2: Not confirmed,
- 3: Not applicable, requesting consideration of alternate standard

20.4.3 Alternate standard. If Applicant provides a majority of covered professional services through providers employed by the Applicant or through a single contracted medical group, it may request to be evaluated under the alternate standard. The alternate standard requires the Applicant to provide services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories listed above and demonstrate that it does so in each geographic rating region where the QHP provides services to Covered California Enrollees, either through its own integrated delivery system or by offering a contract to at least one ECP outside of its system in each such category.

Applicant requesting consideration under the alternate standard must demonstrate eligibility through one of the following:

1. Employed Providers
 - a. Majority of covered services are rendered by providers employed by Applicant **AND**
 - b. Majority of Applicant's contracts with participating providers are at risk under capitation
2. Single Contracted Medical Group
 - a. Majority of covered services are rendered by a single contracted medical group **AND**
 - b. Majority of Applicant's provider services are at risk under capitation

Applicant requesting consideration under the alternate standard must submit a written description showing the following:

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1. How Applicant's network is designed to ensure reasonable and timely access for Low-income, and Medically Underserved individuals (e.g., 24/7 telephone access); **AND**
2. Tracking quantitative data or efforts Applicant will undertake to measure how Low-income and Medically Underserved individuals are accessing needed health care services (e.g., maps of low-income members relative to 30-minute drive time to providers; survey of low-income members experience such as Consumer Assessment of Healthcare Providers Systems (CAHPS) "Getting Needed Care" survey).

Applicant must produce access maps to demonstrate the extent to which it provides services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories. If existing provider capacity does not meet the above criteria, Applicant may be required to provide additional contracted or out-of-network care. Applicants are encouraged to consider contracting with identified ECPs to provide reasonable and timely access for Low-income, Medically Underserved communities.

Applicant must confirm whether it is requesting evaluation under the alternative ECP standard.

Single, Pull-down list.

1: Confirmed, requesting consideration of alternate standard, explanation, including explanation of alternate standard eligibility, and access maps attached,

2: Not requesting consideration under the alternate standard.

20.5 Delivery System and Payment Strategies to Drive Quality

Attachment 1 of the Covered California Qualified Health Plan (QHP) Issuer Contract embodies Covered California's vision for delivery system reform and serves as a roadmap to delivery system improvements. A number of the delivery system and payment strategy requirements in Attachment 1 meet the federal Quality Improvement Strategy (QIS) requirements.

The Patient Protection and Affordable Care Act (§1311(g)(1)) requires periodic reporting to Covered California of activities a QHP Issuer has conducted to implement a strategy for quality improvement. This strategy is defined as a multi-year improvement strategy that includes a payment structure that provides increased reimbursement or other incentives for improving health outcomes, reducing hospital readmissions, improving patient safety, and reducing medical errors, implementing wellness and health promotion activities, and reducing health and health care disparities. QHP Issuers must implement and report on a quality improvement strategy or strategies consistent with the standard of section 1311(g) of the ACA.

Applicants that are currently operating in Covered California are required to complete QIS workplans as part of the Application process. The following strategies meet the QIS requirements and Applicants must submit QIS workplans:

- Comprehensive Pregnancy and Postpartum Care
- Hospital Quality, Value, and Patient Safety

QHP certification is conditioned on Applicant developing a multi-year QIS and reporting year-to-year activities and progress on each initiative area.

Applicants that are not currently operating in Covered California are not required to complete the QIS workplan updates as part of the Application for 2027 but must review Attachment 1 with the understanding that engagement in the QIS and Attachment 1 initiatives will be contractually required and measured in the future if Applicant contracts with Covered California.

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20.5.1 Provider Networks Based on Value

All questions are required for new entrant Applicants. All questions should be answered at the product level, not at the Issuer level.

Applicant shall curate and manage its network(s) to address variation in quality and cost performance across network hospitals and providers, with a focus on improving the performance of hospitals and providers. Applicant shall measure, analyze, and reduce variation to achieve consistent high performance for all network hospitals and providers. Applicant shall hold its contracted hospitals and providers accountable for improving quality and managing cost and provide support to its contracted hospitals and providers to improve performance. The following questions address Applicant's ability to track and address variation in quality and cost performance across network hospitals and providers.

20.5.1.1 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers and hospitals for determining initial and ongoing network inclusion, and briefly explain how each measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Hospital Quality	Multi, Checkboxes. 1: Cal Hospital Compare data, 2: California Maternal Quality Collaborative data, 3: Leapfrog Group data, 4: CMS Hospital Quality Reporting, 5: Program or another CMS program, 6: Designated Center of Excellence (COE), 7: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Hospital Cost	Multi, Checkboxes. 1: Percent of Medicare rates, 2: Diagnosis-Related Group (DRG) costs, 3: Comparison to other hospital costs in geographic area, 4: Comparison to other hospital costs by decile or other method, 5: CMS Hospital Price Transparency data, 6: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Additional Criteria	100 words.	100 words.	100 words.	100 words.

20.5.1.2 Applicant must identify key quality and cost sources and measures that the Applicant uses to evaluate providers for determining initial and ongoing network inclusion, and briefly explain how each

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measure is used, including if and how the measure is used for performance payment. Applicant must also describe any additional criteria used to determine network inclusion.

	<i>Data Source</i>	<i>Purpose</i>	<i>Provide examples if response #4 selected for Purpose</i>	<i>Provide details if Other selected in Data Source or Purpose</i>
Provider Quality	Multi, Checkboxes. 1: Integrated Healthcare Association data, 2: Office of Patient Advocate data, 3: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Provider Cost	Multi, Checkboxes. 1: Total Cost of Care data, 2: Comparison to other physician or physician groups in geographic area, 3: Other, explain	Multi, Checkboxes. 1: Used for initial contracting assessment, 2: Used for re-contracting assessment, 3: Has been used for incentive or Pay for Performance payments, 4: Has been used for termination or exclusion (give examples), 5: Other, explain	100 words.	100 words.
Additional Criteria	100 words. Nothing required	100 words. Nothing required	100 words.	100 words.

20.5.2 Advanced Primary Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California recognizes that providing high-quality, equitable, and affordable care requires a foundation of effective and patient-centered primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Applicant shall actively promote the development and use of advanced primary care models that promote access, care coordination, and quality while managing the total cost of care. The following questions address Applicant's ability to match at least 95% of enrollees with a primary care clinician and increase the proportion of providers paid under a payment strategy that promotes advanced primary care.

20.5.2.1 Applicant must report the percentage of Covered California Enrollees who either selected or were matched with a primary care clinician in 2026 in Attachment J_QHP-IND_Run Charts. If Applicant had no Covered California business in 2026, report full 2026 book of business excluding

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Medicare. Applicants currently contracted with Covered California must enter the number and percentage of enrollees who either selected or were matched with a primary care clinician reported in the Certification Application for 2026 and 2027. Report data by product (HMO, PPO, EPO, Other).

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

20.5.2.2 Applicant must report all payment methods used for primary care services and number of providers paid under each category in 2026 in Attachment J_QHP-IND_Run Charts as outlined by the Office of Health Care Affordability (OHCA). If Applicant had no Covered California business in 2026, report full 2026 book of business excluding Medicare. Applicants currently contracted with Covered California must enter the number and percentage of providers paid under each model reported in the Certification Applications for 2026 and 2027, including the payment strategies for the top five (5) physician groups. Report data by product (HMO, PPO, EPO, Other). References: HCP LAN Alternative Payment Model APM Framework: <https://hcai.ca.gov/wp-content/uploads/2026/06/THCE-Data-Submission-Guide-v3.0.pdf>

Single, Pull-down list.

- 1: Attached,
- 2: Not attached

20.5.3 Comprehensive Pregnancy and Postpartum Care

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

According to the World Health Organization, maternal health refers an individual's health during pregnancy, childbirth, and the postpartum period. Covered California is committed to addressing all three phases to provide a comprehensive approach to pregnancy and postpartum health.

Applicant must:

- 1) Progressively adopt physician and hospital payment strategies so that revenue for labor and delivery only supports medically necessary care and no financial incentive exists to perform a low-risk Nulliparous Term Singleton Vertex (NTSV) Cesarean Section (C-Section).
- 2) Promote improvement work through the California Maternal Quality Care Collaborative (CMQCC) Maternal Data Center (MDC), so that all maternity hospitals work toward reducing pregnancy and postpartum health disparities in alignment with Department of Health Care Services (DHCS).
- 3) Consider a hospital's NTSV C-section rate, improvement trajectory, and engagement in quality improvement efforts, such as participation in coaching when making maternity hospital contracting decisions and terms. Covered California recognizes that no single measure should determine network participation; however, sustained performance without demonstrated improvement must be addressed through contracting terms and corrective actions.

New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for NTSV C-sections compared to vaginal deliveries. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote maternal and newborn health and reduce low-value care.

Returning Applicants contracted with Covered California for more than one (1) year must report on these payment methodologies in their Certification Application, including the percentage of network

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hospitals and physicians paid under value-based models that minimize incentives for unnecessary surgical delivery.

Returning Applicants, contracted with Covered California for two (2) or more years must also demonstrate measurable progress in expanding and strengthening these methodologies across their network.

4) Strategize contracting efforts to stabilize the pregnancy and postpartum workforce by expanding the network to include more midwives and doulas, ensuring patients have the autonomy to share their treatment preferences and goals, actively participating in shared decision-making processes with their care team.

20.5.3.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's pregnancy and postpartum payment requirements, supporting medically necessary, high-value care and reducing low-value care, and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered California for two (2) or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select "Not applicable."

Single, Pull-down list.

1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements.,

2: Not confirmed,

3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

20.5.3.2 Applicant must report number of all network hospitals reporting to the California Maternity Quality Care Collaborative (CMQCC) Maternal Data Center (MDC) in 2026 in Attachment J_QHP-IND_Run Charts. A list of all California hospitals participating in the MDC can be found here: <https://www.cmqcc.org/about-cmqcc/member-hospitals>. Applicants currently contracted with Covered California must enter the percentage reported in the Certification Applications for 2024, 2025, 2026 and 2027 as well, if applicable.

Single, Pull-down list.

1: Attached,

2: Not attached

20.5.3.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must adopt and expand value-based payment strategies structured to support medically necessary, high-value care that promotes health, resilience, and disease prevention for the pregnancy and postpartum patient and their family with no financial incentive to perform non-medically necessary NTSV C-sections for all contracted physicians and hospitals by year end 2026 or in the first year of QHP certification if after 2026. These value-based payment strategies include: 1) Blended case rate payment for both physicians and hospitals; 2) Including a NTSV C-section metric in existing hospital and physician quality incentive programs; and 3) Population-based payment models, such as maternity episode payment models.

Applicant must report various reimbursement models for deliveries and number of network hospitals and physicians paid using each payment strategy in 2026 in Attachment J_QHP-IND_Run Charts. Describe all existing payment models for Pregnant and Postpartum delivery procedures. Specifically, explain how the system for paying providers is structured so that there is no financial incentive for NTSV cesarean sections compared to vaginal births.

Applicants currently contracted with Covered California must enter the percentages reported in the Certification Applications for 2024, 2025, 2026, and 2027, if applicable.

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Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, new entrant Applicant

20.5.3.4 Currently contracted Applicant of two (2) or more years must complete Attachment K1_QHP-IND-CCSB_QIS 1 Work Plan - Comprehensive Pregnancy and Postpartum Care to describe strategies for the delivery of high value care and report any progress made since the last QIS submission. Each question in this application is designed to assess distinct aspects of the Applicant's strategy, performance, and commitment to continuous improvement.

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on cross-references (e.g., "see previous response") or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select "Not applicable."

Address each of the following in the work plan narrative:

- Description of how Hospital Safety Ratings are communicated to enrollees to promote autonomy in decision making.
- Description of how Applicant engages with its network hospitals to reduce NTSV (non-medically necessary) C-Section rates to 23.6% or less.
- Description of its value-based payment strategies structured to support only medically necessary care with no financial incentive to perform C-sections for all contracted physicians and hospitals by year end 2026.
- Description of the expansion strategy for in-network Doula and Midwife providers.
- Description of how access to culturally and linguistically appropriate pregnancy and postpartum care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postpartum care, and related services are communicated and promoted to enrollees.
- Description of how Applicant promotes and encourages all in-network hospitals that provide pregnancy and postpartum services to use the resources provided by CMQCC and enroll in the CMQCC MDC.
- Updates to hospital participation in CMQCC and hospital engagement in maternity care quality improvement.
- Description of how local social support services such as food, housing, and transportation programs and other resources are available to members in need of additional support in the postpartum period.
- Further implementation plans for 2027 including milestones and targets for 2028 and 2029.
- List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities.

Note: Refer to Appendix M for hospital C-section rates.

Single, Radio group.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, currently contracted Applicant with fewer than two (2) years or new entrant Applicant

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20.5.4 Hospital Quality, Value, and Patient Safety

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer collaborative approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce wasteful healthcare spending.

Applicant must work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients and contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of enrollees. Applicant will improve quality and cost performance across its contracted hospitals and track and report progress and strategies.

New entrant Applicants and returning Applicants contracted with Covered California for fewer than two (2) years must adopt payment methodologies that support only medically necessary, high-value care. Payment structures must not create higher reimbursement for low-value or avoidable services, including hospital-acquired infections (HAIs), readmissions, or other preventable complications. Instead, Applicants are expected to move toward value-based, outcome-focused models, such as bundled or episode-based payments that promote patient safety, improve clinical outcomes, and reduce wasteful spending.

Returning Applicants contracted with Covered California for more than one (1) year must report on hospital payment methodologies in their Certification Application, including the percentage of network hospitals reimbursed under models that tie payment to quality, value, and patient safety (e.g., HAIs, readmissions, patient satisfaction).

Returning Applicants contracted with Covered California for two (2) or more years, must also demonstrate measurable progress in expanding and strengthening value-based hospital payment strategies across their network and show collaboration efforts with other QHP issuers to improve hospital safety and reduce hospital-acquired infections.

20.5.4.1 Applicant confirms that it is applying as a new entrant or as a returning applicant with fewer than two (2) years of participation with Covered California. Applicant understands that, upon contracting with Covered California, it must adopt Covered California's pregnancy and postpartum payment requirements, supporting medically necessary, high-value care and reducing low-value care, and must submit a Quality Improvement Strategy (QIS) work plan once contracted with Covered California for two (2) or more years. If Applicant is currently contracted for two (2) or more years, Applicant may select "Not applicable."

Single, Pull-down list.

1: Confirmed, Applicant is a new entrant or returning applicant with fewer than two (2) years of participation and understands the requirements.,

2: Not confirmed,

3: Not Applicable, Applicant is a returning applicant with two (2) or more years of participation.

20.5.4.2 Applicants must report progress on the adoption of hospital payment methodologies for each general acute care hospital in its networks that ties payment to quality, value and safety. Report, across all lines of business, excluding Medicare, the percentage of hospital reimbursements tied to quality and safety and the metrics applied for performance-based payments in Attachment J_QHP-IND_Run Charts. In the details section of the spreadsheet, describe the performance-based payment strategy structure used to put payments at risk, and note if more than one structure is used. "Quality performance" includes any number or combination of metrics, including HAIs, readmissions, patient satisfaction, etc. In the same sheet, report metrics used to assess quality performance.

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Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, new entrant Applicant

20.5.4.3 Currently contracted Applicants that have participated with Covered California for one (1) or more years must report the number and percent of hospitals contracted under the model described in question 20.5.4.2 with reimbursement at risk for quality performance in 2026 in Attachment J_QHP-IND_Run Charts.

Single, Pull-down list.

- 1: Attached,
- 2: Not attached,
- 3: Not Applicable, new entrant Applicant

20.5.4.4 Currently contracted Applicant of (2) or more years must complete Attachment K2_QHP-IND-CCSB_QIS 2 Work Plan-Hospital Quality, Value, Patient Safety to describe progress promoting hospital safety since the last submission. Address each of the following in the work plan narrative: How Applicant is engaging with its network hospitals to reduce the five specified HAIs to achieve a Standardized Infection Ratio (SIR) of 1.0 or lower for each of the specified HAIs How Applicant aims to improve adherence to the Sepsis Management (SEP-1) guidelines How Applicant is leveraging the poor performing hospitals list provided by Cal Hospital Compare to collaborate with other QHP Issuers who contract with the same poor performing hospitals Progress in adopting a payment strategy that ties hospital payment to quality, value, and safety Collaborations with other QHP Issuers on approaching hospitals to suggest quality improvement program participation or alignment on a payment strategy to tie hospital payment to quality Further implementation plans for 2027 including milestones and targets for 2028 and 2029 List any known or anticipated barriers in implementing QIS activities and progress of mitigation activities

Responses must directly and independently address each item below. Applicants may not submit prior year QIS documents in lieu of updated responses. Answers that rely solely on cross-references (e.g., “see previous response”) or duplicate content from previous submissions will be considered incomplete and may be deemed non-responsive. Applicants are encouraged to provide clear, specific, and tailored responses that include relevant, quantifiable metrics (e.g., outcome targets, provider participation rates, reductions in intervention rates, network growth percentages), describe known or anticipated challenges and mitigation strategies, and articulate future goals and milestones for Plan Year 2028 and beyond. If Applicant is currently contracted for fewer than two (2) years or a new entrant Applicant, Applicant may select “Not applicable.”

Note: In addition to hospital HAI rates in Appendix M, refer to the following publicly available resources available to hospitals: CMS Quality Improvement Organization (QIO) Program:

<https://www.cms.gov/medicare/quality/quality-improvement-organizations>

Health Services Advisory Group (HSAG) Quality Improvement and Innovation for Region 7:

<https://www.hsag.com/en/medicare-providers/hospitals/>

Hospital HAI rates can be reviewed individually at: <http://calhospitalcompare.org/>

Single, Radio group.

- 1: Attached,
- 2: Not attached,
- 3: Not applicable, Applicant contracted for fewer than two (2) years with Covered California

20.6 Cost Containment

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20.6.1 Cost Containment for Statewide Spending

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California collaborates closely with the California Department of Health Care Access and Information (HCAI) and the Office of Health Care Affordability (OHCA) to ensure the public interest is served by enabling all Californians to access health care that is not only accessible and affordable but also equitable, of high quality, and universally available. In its role as the state-based marketplace, Covered California actively monitors the advancement toward reduced overall healthcare expenditures across the state and manages strategies for cost containment. In this section, Applicants will be assessed on the degree to which cost growth targets have been incorporated into pricing models and contracting strategies.

20.6.1.1 Applicant must describe strategies in place for cost containment based on OHCA's Health Care Spending Target. For each targeted service category (e.g., facility inpatient, facility outpatient, professional inpatient, professional outpatient, Mental Health and Substance Abuse (MHSA), lab, radiology, specialty pharmacy, prescription drug):

- Name and describe the service category or categories being targeted.
- Provide the specific strategy or strategies used (e.g., network curation, value-based contracting, site-of-care optimization, utilization management, price negotiation, etc.).
- Specify applicable lines of business, noting any differences (e.g., Covered California Individual Market, CCSB, off-Exchange).
- Briefly note progress to date, future targets, how quality is integrated and access preserved, quantifiable metrics (e.g., % reductions, cost trends, quality outcomes), and any key challenges with mitigation approaches.
- Highlight how these strategies reduce costs for members by enabling other levers, such as premium reduction.

200 words.

20.6.1.2 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. Covered California is interested in learning about the Applicant's analysis regarding its own costs, such as identifying the root cause(s) of increasing costs in these areas. For each of these 3 cost drivers, identify and describe the root cause(s) of increasing costs, if identified by Applicant. If Applicant has not identified the root cause(s) of increasing costs in these areas, indicate this below.

Multi, Checkboxes.

- 1: Identify and describe the root cause(s) for high cost for specialty pharmacy: [200 words].
- 2: Identify and describe the root cause(s) for high cost for ER visits: [200 words].
- 3: Identify and describe the root cause(s) for high cost for ambulance: [200 words].

20.6.1.3 Covered California has identified specialty pharmacy, Emergency Department visits, and ambulance services as market-wide cost drivers. For each of these 3 cost drivers, describe any strategies Applicant has implemented to contain cost.

Multi, Checkboxes.

- 1: Describe cost containment strategies for specialty pharmacy: [200 words].
- 2: Describe cost containment strategies for ER visits: [200 words].
- 3: Describe cost containment strategies for ambulance: [200 words].

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20.6.1.4 Applicant must describe strategies it has implemented to reduce premiums for members.
200 words.

20.6.2 Cost Containment for Formulary Pricing

All questions are required for all Applicants. All questions should be answered at the product level, not at the Issuer level.

Covered California is concerned with the trend in rising prescription drug costs, as pharmacy trend has outpaced medical trend for several years. These rising prescription drug costs include specialty pharmacy, and compounding increases in costs of generic drugs, which are a growing driver of total cost of care. In this section, Applicants will be assessed on the extent to which value, including cost, access, and clinical outcomes, is considered in the construction of formularies, Pharmacy Benefit Management (PBM) relationships, and delivery of pharmacy services.

20.6.2.1 Applicant must describe strategies to improve member affordability of pharmaceuticals. In the response, include the structure of pharmacy network partners, use of product and service carve-outs, and the application drug price benchmarking tools (e.g., ICER and NADAC). Specify whether and how rebates, spread pricing and comprehensive audit rights are leveraged through fair and competitive contracting practices. Highlight how these strategies reduce costs for members and support long-term value in the pharmacy benefit.

200 words.

20.6.2.2 Applicant must describe how it incorporates value (maximizing outcomes achieved per dollar spent) and cost-effectiveness (relative value of different treatments) in its formulary design. Specify the data sources, evaluation methods (e.g., comparative effectiveness, health outcomes data), and clinical or financial criteria used to inform decisions. If applicable, describe any resulting impacts on formulary structure, tiering, or member affordability. Responses must be specific and demonstrate how value and cost-effectiveness considerations influence actual formulary decisions.

200 words.

20.6.2.3 Applicant must describe strategy for managing specialty pharmacy and biologic therapies, including Glucagon-like peptide-1 (GLP-1) receptor agonists. Include how the strategy supports clinical appropriateness, member affordability, and cost-effective utilization. Describe any use of utilization management tools (e.g., prior authorization, step therapy, site-of-care optimization), network design, or contracting arrangements. Where applicable, highlight how these approaches have impacted access, member experience, health outcomes, or total cost of care.

200 words.

20.6.2.4 Does Applicant promote and use biosimilar drugs? If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

20.6.2.5 Does Applicant provide decision support for prescribers and enrollees in selecting appropriate, efficacious, high-value treatments and more cost-effective alternatives when applicable?

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If yes, describe Applicant's approach, including prescribing support, member communication, or strategies to increase uptake.

Single, Radio group.

1: Yes, describe: [50 words] ,

2: No

21 Glossary

Abuse - Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use. The intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive abuse of one's position or authority. Often, the terms fraud and abuse are used interchangeably. The primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include, but not limited to, excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

Applicant - A Health Insurance Issuer who is applying to have its plans certified as Qualified Health Plans.

At-Risk Enrollee - is a Covered California Enrollee who is:

- a) in the middle of acute treatment, or who would otherwise qualify for Continuity of Care under California law,
- b) in case management programs,
- c) in disease management programs, or
- d) on maintenance prescription drugs for chronic condition.

California Commercial - Includes individual and group lines of business.

Certification Year - The year for which Applicant is applying for proposed product(s) to be certified.

Coverage Year - The year the benefits will cover an enrollee.

Covered California Enrollee - Refers to every individual enrolled in Covered California for the purpose of receiving health benefits. Also referred to as "On-Exchange".

Current Year - The calendar year in which the Applicant is completing application for certification of proposed product(s).

Definition of Good Standing - Department of Insurance - Verification that issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent market conduct exam reviewed.

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Affirmation of no material² statutory or regulatory violations, including penalties levied, in the past two (2) years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using the certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met - provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review - Geographic rating regions and rate development justification is consistent with ACA requirements.

Definition of Good Standing - Department of Managed Health Care - Verification that issuer holds a state health care service plan license or insurance certificate of authority: Approved for lines of business sought in the Exchange (e.g., commercial, small group, individual; Approved to operate in what geographic service areas and most recent financial exam and medical survey report reviewed.

Affirmation of no material² statutory or regulatory violations, including penalties levied, in the past two (2) years in relation to any of the following, where applicable: Financial solvency and reserves reviewed; Administration and organizational capacity acceptable; Benefit Design; State mandates (to cover and to offer) - Essential health benefits (State required), Basic health care services, Copayments, deductibles, out-of-pocket maximums, Actuarial value confirmation (using the certification year Federal Actuarial Value Calculator); Network adequacy and accessibility standards are met - provider contracts; Language access; uniform disclosure (summary of benefits and coverage); Claims payment and policies and practices; Enrollee/Member grievances/complaints and appeals policies and practices; Independent medical review; Marketing and advertising; Guaranteed issue individual and small group; Rating Factors; Medical Loss Ratio; Premium rate review - Geographic rating regions and rate development justification is consistent with ACA requirements.

Enrollee - Refers to every individual enrolled for the purpose of receiving health benefits, including Covered California Enrollees and Off-Exchange membership.

Fraud - Consists of an intentional misrepresentation, deceit, or the concealment of a material fact known to the defendant with the intention of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include, but are not limited to, false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Generative Artificial Intelligence (GenAI) - Artificial Intelligence (AI) systems capable of creating content, predictions, or decisions from data inputs. This encompasses machine learning, natural language processing, and neural network technologies.

Healthcare Consumer or Consumer - Covered California uses this term consistent with the Health Consumers NSW definition: A 'consumer' tends to choose and get involved in decision making, whereas traditionally a 'patient' tends to be a person who receives care without necessarily taking part

² Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

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in decision making. <https://www.hcnsw.org.au/consumers-toolkit/who-is-a-health-consumer-and-other-definitions/>.

Health Issuer - A licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through Covered California, as specified in 10 CCR § 6410.

Internal Audit Function - A professional individual or group responsible for providing an organization with assurance and advisory services. Internal Auditing is an independent, objective assurance and advisory service designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of governance, risk management, and control processes.

Member Portal - Covered California uses this term consistent with the Law Insider dictionary definition: Member Portal means information secured behind an authentication wall which will require a unique username and password combination, and which will grant the User access to customized information pertaining only to the User and those Beneficiaries (where applicable) linked to the User. <https://www.lawinsider.com/dictionary/member-portal>.

Member Services - Covered California uses this term consistent with the Law Insider dictionary definition: Member Services means a method of assisting enrollees in understanding CONTRACTOR policies and procedures, facilitating referrals to participating specialists, and assisting in the resolution of problems and member complaints. The purpose of Member Services is to improve access to services and promote enrollee satisfaction. <https://www.lawinsider.com/dictionary/member-services>.

Waste - Intentional or unintentional, extravagant careless or needless expenditures. The consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.